

MONTANA LEGISLATIVE HISTORY

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Chapter 714 19 91

Bill H _____ S 256 Original bill & history ____ C

H. Committee on Human Services & Aging

Hearing Date(s) Mar 19 ✓ C

Mar 22 ✓ C

_____ C

_____ C

Date Out Mar 23 ✓ C

S. Committee on Business & Industry

Hearing Date(s) Feb 07 ✓ C

_____ C

_____ C

_____ C

Feb 15 ✓ C

Did this bill originate in an interim committee? ____ Yes ____ No

Committee _____

Report _____

SENATE FINAL STATUS

SB 256

2/11	2ND READING PASSED	48	0
2/12	3RD READING PASSED	48	0
	TRANSMITTED TO HOUSE		
2/13	FIRST READING		
2/13	REFERRED TO HUMAN SERVICES & AGING		
3/14	HEARING		
3/15	COMMITTEE REPORT—BILL CONCURRED		
3/15	PLACED ON CONSENT CALENDAR		
3/18	3RD READING CONCURRED	93	5
	RETURNED TO SENATE		
3/23	SIGNED BY PRESIDENT		
3/23	SIGNED BY SPEAKER		
3/25	TRANSMITTED TO GOVERNOR		
3/29	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 279		

EFFECTIVE DATE: 7/01/91

SB 255 INTRODUCED BY VAUGHN, ET AL.

REQUIRE THAT FISH BAIT CONTAINERS BE BIODEGRADABLE

2/01	INTRODUCED		
2/01	REFERRED TO FISH & GAME		
2/02	FIRST READING		
2/19	HEARING		
2/20	COMMITTEE REPORT—BILL PASSED		
2/21	2ND READING PASSED	49	0
2/22	3RD READING PASSED	43	6
	TRANSMITTED TO HOUSE		
3/04	FIRST READING		
3/04	REFERRED TO FISH & GAME		
3/15	HEARING		
3/18	TABLED IN COMMITTEE		

SB 256 INTRODUCED BY GAGE, ET AL.

AMEND THE PREFERRED PROVIDER AGREEMENTS ACT

2/01	INTRODUCED		
2/01	REFERRED TO BUSINESS & INDUSTRY		
2/02	FIRST READING		
2/07	HEARING		
2/18	COMMITTEE REPORT—BILL PASSED		
2/19	2ND READING PASSED	37	13
2/20	3RD READING PASSED	38	12
	TRANSMITTED TO HOUSE		
3/04	FIRST READING		
3/04	REFERRED TO HUMAN SERVICES & AGING		
3/19	HEARING		
3/23	COMMITTEE REPORT—BILL CONCURRED		
4/05	2ND READING CONCURRED	73	25
4/06	3RD READING CONCURRED	82	14
	RETURNED TO SENATE		
4/11	SIGNED BY PRESIDENT		
4/12	SIGNED BY SPEAKER		
4/12	TRANSMITTED TO GOVERNOR		
4/17	RETURNED TO SENATE WITH GOVERNOR'S AMENDMENTS		
4/18	2ND READING GOVERNOR'S AMENDMENTS		
	CONCURRED	45	2
4/19	3RD READING GOVERNOR'S AMENDMENTS		
	CONCURRED	47	2
	TRANSMITTED TO HOUSE		
4/22	2ND READING GOVERNOR'S AMENDMENTS		
	CONCURRED	83	11

4/24 SIGNED BY PRESIDENT
 4/25 SIGNED BY SPEAKER
 4/25 TRANSMITTED TO GOVERNOR
 4/29 SIGNED BY GOVERNOR
 CHAPTER NUMBER 714

EFFECTIVE DATE: 4/29/91

SB 257 INTRODUCED BY GAGE

CLARIFY STATUS OF CERTAIN PERSONNEL OF THE
 DEPARTMENT OF JUSTICE

BY REQUEST OF DEPARTMENT OF JUSTICE

2/01 FISCAL NOTE REQUESTED
 2/01 INTRODUCED
 2/01 REFERRED TO JUDICIARY
 2/02 FIRST READING
 2/07 FISCAL NOTE RECEIVED
 2/08 FISCAL NOTE PRINTED
 2/15 HEARING
 2/16 COMMITTEE REPORT—BILL PASSED AS AMENDED
 2/19 2ND READING PASSED AS AMENDED
 2/20 3RD READING PASSED

50 0
 49 0

TRANSMITTED TO HOUSE
 3/04 FIRST READING
 3/04 REFERRED TO JUDICIARY
 3/15 HEARING
 3/15 COMMITTEE REPORT—BILL CONCURRED
 3/15 PLACED ON CONSENT CALENDAR
 3/18 3RD READING CONCURRED

97 1

RETURNED TO SENATE
 3/23 SIGNED BY PRESIDENT
 3/23 SIGNED BY SPEAKER
 3/25 TRANSMITTED TO GOVERNOR
 3/29 SIGNED BY GOVERNOR
 CHAPTER NUMBER 280

EFFECTIVE DATE: 10/01/91

SB 258 INTRODUCED BY T. BECK

PROVIDE FOR FILING SECURITY INTEREST ON OFF-HIGHWAY
 VEHICLES

BY REQUEST OF DEPARTMENT OF JUSTICE

2/01 INTRODUCED
 2/01 REFERRED TO BUSINESS & INDUSTRY
 2/02 FIRST READING
 2/08 HEARING
 2/21 TABLED IN COMMITTEE

SB 259 INTRODUCED BY FRANKLIN, ET AL.

CLARIFY DUTY OF DEPARTMENT OF HEALTH TO PROVIDE
 CONSULTATION SERVICES FOR HEALTH NURSES

2/02 INTRODUCED
 2/04 REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY
 2/04 FIRST READING
 2/09 FISCAL NOTE REQUESTED
 2/11 HEARING
 2/14 COMMITTEE REPORT—BILL PASSED
 2/16 FISCAL NOTE RECEIVED
 2/16 FISCAL NOTE PRINTED
 2/16 2ND READING PASSED
 2/18 3RD READING PASSED

33 15
 32 18

TRANSMITTED TO HOUSE
 3/04 FIRST READING

1 *Senate* BILL NO. 256
 2 INTRODUCED BY *Rep. Lynch*
 3
 4 A BILL FOR AN ACT ENTITLED: "AN ACT AMENDING THE PREFERRED
 5 PROVIDER AGREEMENTS ACT TO REQUIRE HEALTH CARE INSURERS TO
 6 ENTER INTO PREFERRED PROVIDER AGREEMENTS WITH ALL HEALTH
 7 CARE PROVIDERS WILLING TO PROVIDE HEALTH CARE SERVICES UNDER
 8 A PREFERRED PROVIDER AGREEMENT; AMENDING SECTION 33-22-1704,
 9 MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

10
 11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

12 **Section 1.** Section 33-22-1704, MCA, is amended to read:

13 "33-22-1704. Preferred provider agreements authorized.

14 (1) Notwithstanding any other provision of law to the
 15 contrary, a health care insurer may:

16 (a) enter into agreements with providers relating to
 17 health care services that may be rendered to insureds or
 18 subscribers on whose behalf the health care insurer is
 19 providing health care coverage, including preferred provider
 20 agreements relating to:

21 (i) the amounts an insured may be charged for services
 22 rendered; and

23 (ii) the amount and manner of payment to the provider;
 24 and

25 (b) issue or administer policies or subscriber

1 contracts in this state that include incentives for the
 2 insured to use the services of a provider that has entered
 3 into an agreement with the insurer pursuant to subsection
 4 (1)(a).

5 (2) A health care insurer shall establish terms and
 6 conditions to be met by providers wishing to enter into an
 7 agreement with the health care insurer under subsection
 8 (1)(a). These terms and conditions may not discriminate
 9 against or among providers. For the purposes of this
 10 subsection, price differences among hospitals or other
 11 institutional providers produced by a process of individual
 12 negotiation or by price differences among different
 13 geographical areas or different specialties do not
 14 constitute discrimination. A health care insurer may not
 15 deny a provider the right to enter into an agreement under
 16 subsection (1)(a) if the provider is willing to meet the
 17 terms and conditions established in that agreement.

18 ~~(2)(3)~~ A preferred provider agreement issued or
 19 delivered in this state may not unfairly deny health
 20 benefits for health care services covered.

21 ~~(3)---This---part---does---not---require---that---an---insurer~~
 22 ~~negotiate---or---enter---into---agreements---with---any---specific~~
 23 ~~provider---or---class---of---providers:--"~~

24 NEW SECTION. Section 2. Effective date. [This act] is
 25 effective on passage and approval.

-End-
 -2-

INTRODUCED BILL

MINUTES

MONTANA SENATE 52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By Chairman J.D. Lynch, on February 7, 1991, at
10:00 a.m.

ROLL CALL

Members Present:

J.D. Lynch, Chairman (D)
John Jr. Kennedy, Vice Chairman (D)
Betty Bruski (D)
Delwyn Gage (R)
Thomas Hager (R)
Jerry Noble (R)
Gene Thayer (R)
Bob Williams (D)

Members Excused: Betty Bruski (D)

Staff Present: Bart Campbell (Legislative Council).

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Announcements/Discussion: None

HEARING ON SENATE BILL 256

Presentation and Opening Statement by Sponsor:

Senator Gage, sponsor of the bill, stated that this bill is the remains from a house keeping measure. As sponsor of the bill, he has made no commitments at this point in regards to the bill. It is very unusual that the sponsor of the bill make a recommendation that a bill do not pass, but at this point that is just as possible as the bill passing.

Proponents' Testimony:

Larry McGovern, director of Montana association of physicians, spoke in favor of the bill. If Montana's economy was healthy and bubbling over with good health, his interest in this subject may not be what it is. Competition is healthy for all and exclusions from PPO programs should competitively based only. (See Exhibit 6). He urged the committee to endorse this bill and don't tamper with the one part of our economy that is enjoying some success at this time.

Jim Paquette, president of st. vincent hospital in Billings, spoke in favor of the bill (See Exhibit 3).

Jim Harrington, president Montana hospital association, spoke in favor of the bill. He stated that are 56 hospital members in Montana, 54 are rural hospitals by the federal definition. PPO's may work in another state, they are not for Montana. He likes the idea of a willing provider and an equal playing field.

Carl Hanson, administrator of pondera medical center, spoke in favor of the bill. This bill attempts to maintain access of healthcare in rural communities. If all hospitals have the same opportunity to meet negotiated prices for any group of insurers within their area, rural facilities would be able to keep their market share. Without out this piece of legislation Montana residents will experience less access to healthcare. This bill would allow all hospitals, physicians to participate in more preferred provider agreements thus keeping more of our healthcare resources distributed through the state. He asked that the committee consider the importance of access to healthcare, choice of providers, and distribution of healthcare resources.

Tony Hamm, family physician in Choteau, spoke in favor of the bill. He stated that he is not against PPO's, but he is not in favor of giving insurance companies the right to decide who's going to provide their healthcare. That decision should be made by the physician and their patients. Unless SB 256 passes, Blue Cross has the ability to pick and choose physicians at will. Physicians that practice in small communities run the risk of being cut out completely. It is very difficult to try to recruit physicians to the state, he has been trying for two years. Blue Cross's ability to carve up the market discourages physicians to come to Montana.

David Cunningham, director of rimrock foundation, spoke in favor of the bill (See Exhibit 1).

Pat Melby, representing rimrock foundation, spoke in favor of the bill. He submitted a personal letter written by Paul Gatzemeier (See Exhibit 2). A PPO is a fine concept. It works well in urban areas where there are many healthcare providers, and in areas where one insurance company doesn't have a near monopoly. It works well in areas where most of the hospitals are private or profit facilities. It works in areas where large urban hospitals aren't competing with one another and not with small rural hospitals located near by in small rural communities. A PPO concept will not work in Montana without some restrictions. He then submitted a list of 26 premiums written in Montana (See Exhibit 2A). He stated that blue cross blue shield has a near monopoly. This bill would insure the consumers that need healthcare would have the freedom to choose a provider without having to pay the penalty.

Mona Jamison, representing rocky mountain treatment center, spoke in favor of the bill. As a matter of public policy for this state to what extent does the state wish to support or not support a monopolistic arrangement of the primary health insurers in the state. To what extent as a matter of public policy does this state wish to limit access to healthcare providers being the

individual providers for the facilities which provide the services. This bill gives the legislature the an opportunity to speak out on those two issues. She submitted some amendments (See Exhibit 4).

Dave Barnhill, deputy insurance commissioner testifying on behalf of the insurance department, spoke in favor of the bill. He stated that senate bill 258 would encourage competition, and he urged a do pass.

Ann Bellwood, director of the rocky mountain treatment center in Great Falls, spoke in favor of the bill. She stated how do you define a system of healthcare where there is total control by one institution. This bill is an important measure for us to be able to take our right of freedom of choice for healthcare providers through out the state.

Jerry Lyndorf, representing the Montana medical association, spoke in favor of the bill. He stated that he supports this bill because of the concern of access to physician healthcare throughout the state. There are 18 counties in the state that do not have physician services, and are finding difficulty in finding replacements.

Opponents' Testimony:

Steve Brown, representing blue cross blue shield of Montana, spoke in opposition of the bill. His concern if this bill passes, is will it make healthcare insurance more or less expensive, will it force some insurers to go without insurance. A PPO is an agreement by services on a discounted fee for service basis for a returned or guaranteed volume of patients. He continued by explaining the handouts (See Exhibit 5 and 5A). Blue cross blue shield's only competitor is no insurance at all.

Randy Cline, vice president for the securities division of blue cross blue shield, spoke in opposition of the bill. He stated that the issue of access is really truly not an issue. The physician and patient ultimately decide what hospital that they are going to use. Blue cross's biggest competitor is no insurance at all. It was mentioned earlier that this is a rural issue, that there is a possibility that rural hospitals will refuse business to PPO. This isn't a rural issue.

Tom Hopgood, representing the health insurance association of America, spoke in opposition of the bill. He stated that neither himself nor Steve Brown represent the biggest insurer in Montana which is no insurance. He then went on to say that the issue that PPO's are adversely affecting rural hospitals is simply not true.

Bob Doolen, senior vice president of administration finance for deaconess medical center in Billings, spoke in opposition of the bill. He stated that the basic economics are that healthcare is a very complex system. The idea that the PPO-law will reduce costs to more people is simply not true. These programs are difficult and expensive to put together and difficult and expensive to disassemble. It is in the interest of the healthcare community in total that you can recognize the stability of the PPO.

David Hartman, representing the Montana education association, spoke in opposition the bill (See Exhibit 6).

Ziggy Ziegner, newly elected county commissioner representing yellowstone county, stated that he is neither for nor against the able provider. In his case the PPO allows yellowstone county to realize an estimated yearly savings in excess of one hundred thousand dollars. This is substantial cause to secure the best medical service available, or the best rate available. So as to not only meet the criteria of their establishment of the county health program, but also save tax payers money.

Dale Hoffman, an independent insurance agent in Billings, spoke in opposition of the bill. He is here representing his clients who are generally small businessmen who oppose this legislation. This piece of legislation is designed to neutralize price competition amongst federal care providers. It will level the playing field for the medical care providers.

Larry Williams, superintendent of schools in Great Falls, Montana, spoke in opposition of the bill. He stated that they oppose this piece of legislation because it would strain their purgatives as a major consumer of healthcare insurance.

Bruce Moerer, representing the school board association, spoke in opposition of the bill. This piece of legislation will reduce their ability to negotiate the best buy in healthcare.

Jim Carlson, district marketing manager for blue cross blue shield in Billings, spoke in opposition of the bill. Major employers have purchased this program with significant savings in healthcare plans.

Larry Akey, representing the Montana association of life underwriters, spoke in opposition of the bill. This bill will level the playing field upwards. This is not a bill that is a question of the insurance industry on one hand and the healthcare service provider on the other. This is the healthcare service provider that insures consumers. It is that simple.

Questions From Committee Members:

Senator Noble asked because Carl Hanson's costs are a lot lower, wouldn't this PPO plan put him in a perfect place to be a low bidder.

Carl Hanson responded by saying that his hospitals cost for admission was substantially lower than what was mentioned here today.

Senator Noble stated that one of the biggest concerns is the rural hospitals. Wouldn't preferred provider put him in a better position.

Carl Hanson replied by saying in certain instances yes.

Senator Noble asked because preferred providers is optional, what percentage are PPO's.

Randy Cline responded by saying that the percentage in the Billings area since the PPO has started is probably around 60%. As a total, the total percentage all over the state is very small.

Senator Noble stated that you say the PPO is only going to

SENATE BUSINESS & INDUSTRY COMMITTEE

February 7, 1991

Page 5 of 6

be a worthwhile venture in an urban area, when what other areas will come on line.

Randy Cline stated that they would like to see it in 1991, however this is a excellent question that demonstrates the impact of this bill. We have offered in Missoula the PPO contract with both hospitals rather than negotiating with just one hospital.

Senator Williams asked David Cunningham that in his testimony he stated that St. Vincent's rates were previously 10% lower than Deaconess. Is that the way it happens in the towns with two hospitals, what would cause St. Vincent's to be 10% lower.

David Cunningham stated that he could not speak for St. Vincents, but as a consumer that was the general knowledge.

Senator Williams asked if Yellowstone county is self insured or are they involved in the PPO.

Steve Brown stated that they are involved in the PPO.

Senator Williams asked why Yellowstone county wouldn't be self insured.

Steve Brown stated that they are self insured but what they have done is committed their self insurance plan to part of the PPO agreement.

Senator Lynch asked what say does he have as a consumer on the school districts plan to which hospital gets it.

Larry Akey responded the choice that exists there is that once the provider is suggested to you, you can select whatever provider you want.

Senator Gage asked would they support the provision in the bill that says that any insurer including self insurers, must request negotiations from all providers of what ever service it happens to be in the area, and if none are willing to negotiate, then the insurer may negotiate individually with any provider.

Jim Paquette replied that the language is acceptable.

Senator Thayer asked since Tom Hopgood represents the private insurers and is also testifying for this bill does he think that his members will come in and offer similar PPO arrangements with these people that have a great fear of this.

Tom Hopgood stated that there will be movement from the non blue cross blue shield carriers in the state.

Closing by Sponsor:

Senator Gage closed by saying that he is not sure that he is any closer to a decision than he was before the testimony. He would like to visit with the folks on both sides outside the committee. He will try to get any responses back to the committee.

ADJOURNMENT

Adjournment At: 12:15 a.m.

BU020791.SM1

ROLL CALL

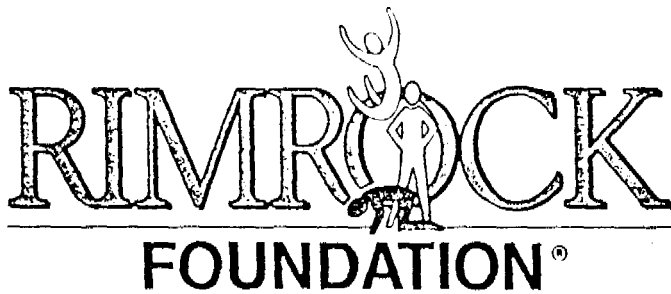
Business&Industry COMMITTEE

DATE 2/7/91

LEGISLATIVE SESSION

NAME	PRESENT	ABSENT	EXCUSED
Senator Bruski			X
Senator Franklin	X		
Senator Gage	X		
Senator Hager	X		
Senator Noble	X		
Senator Thayer	X		
Senator Williams	X		
Senator Kennedy	X		
Senator' Lynch	X		

Each day attach to minutes.



Leading Quality Addiction Treatment in the Northern Rockies

TESTIMONY IN SUPPORT OF SENATE BILL 256

DAVID W. CUNNINGHAM

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 1

DATE 2/7/91

BILL NO. SB256

There has been considerable misunderstanding generated about this proposed bill. Opponents have been busy telling folks that existing state law related to Preferred Provider arrangements should not be changed if you want to lower health costs. Let me describe what they appear to mean by such a statement.

Last May, Blue Cross/Blue Shield entered into a Preferred Provider agreement with one of our two local hospitals-- an agreement that directs members to this hospital for a reduction of 10% in charges for medical services. If a member does not use Deaconess Medical Center, but rather chooses Saint Vincent, a 25% penalty is imposed by Blue Cross. Now, on the surface it sounds like a savings--10%. However, the excluded hospital, Saint Vincent's rates were previously 10% lower than Deaconess. An informed consumer could already purchase services from Saint Vincent for 10% less than Deaconess. Now, however, due to this Preferred Provider contract, the original lower cost provider is penalized. And the PPO member is merely getting the same price at one hospital he could have had at the other.

Last Fall, November, I listened to a Blue Cross official describe their plans for Preferred Providers in Montana. Exclusivity, he stated, is what makes these agreements work--there can only be a few providers under this scheme. Thus, we plan to use only three hospitals, one in Billings, one in Great Falls and one in the Western part of the state. We will do likewise with chemical dependency and psychiatric services."

Exclusivity, we would argue, in a rural state like ours, does not make sense. Perhaps this is why Wyoming has willing provider legislation. With the large market share enjoyed by Blue Cross, permitting them an exclusive PPO, will surely mean the demise of other facilities. What, for example will be the impact in Great Falls of one and only one such exclusive arrangement? How is exclusivity in the best interest of Montanan's? Is'nt exclusivity actually anti-competitive? Should'nt any healthcare provider willing to meet the terms of these agreements, thus lowering costs for patients, be allowed to be a party? We think so, and in so doing, we can all benefit, by reduced costs to patients, and by having the opportunity to stay in business. Lower cost residential facilities such as Rimrock Foundation deserve to continue to be an option for patients--that is what this bill is seeking and we urge you to support it.

1

PAUL GATZEMEIER
7220 CHAROLAIS
BILLINGS, MONTANA 59106

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 12

DATE 2/1/91

BILL NO. SP 236

January 30, 1991

Senator J.D. Lynch, Chairman
Business and Industry Committee
State Capitol
Capitol Station
Helena, MT 59620

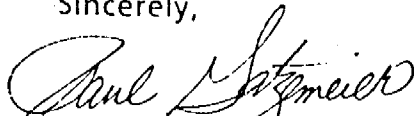
Dear Mr. Lynch:

As a Board member of the Rimrock Foundation, I have a vital interest in Senate Bill 16. At Rimrock we have analyzed the impact on us of a negotiation currently underway between a major health insurance company and facilities here in Billings regarding Preferred Provider Status. It is our conclusion that should these negotiations conclude in a way that it excludes Rimrock Foundation from supplying services to patients covered by this company, it could have such a brutal impact on revenues that it may be the demise of the Rimrock Foundation.

In Montana, and particularly in this part of the state, it is critical that low cost residential facilities such as Rimrock Foundation be afforded every opportunity to provide services and receive third-party reimbursement.

I would support the Willing Provider provision which I understand is to be included in this Legislation.

Sincerely,


Paul Gatzemeier

If

EXHIBIT NO. DADATE 2/7/91BILL NO. SB256

ACCIDENT AND HEALTH

ANK

INSURER

1989 DIRECT A & H
PREMIUMS WRITTEN IN MONTANA

1 BLUE CROSS/BLUE SHIELD OF MT.	\$162,957,526	48.94%
2 PRUDENTIAL INS. CO. OF AMERICA	\$12,481,653	3.75%
3 PRINCIPAL MUTUAL LIFE INS. CO	\$11,470,157	3.45%
4 CONTINENTAL ASSURANCE CO.	\$7,866,843	2.36%
5 BANKERS LIFE AND CASUALTY CO.	\$7,828,448	2.35%
6 MUTUAL OF OMAHA INS. CO.	\$5,675,593	1.70%
7 FEDERAL HOME LIFE INS. CO.	\$4,933,507	1.48%
8 STATE FARM MUTUAL AUTO INS. CO.	\$4,662,290	1.40%
9 JOHN ALDEN LIFE INS. CO.	\$4,600,358	1.38%
10 AETNA LIFE INS. CO.	\$4,429,966	1.33%
11 UNITED OF OMAHA LIFE INS. CO.	\$4,271,658	1.28%
12 TRAVELERS INS. CO.	\$3,349,172	1.01%
13 UNION BANKERS INS. CO.	\$3,324,206	1.00%
14 AETNA LIFE INSURANCE & ANNUITY CO.	\$3,312,481	0.99%
15 LIFE INVESTORS INS. CO. AMERICA	\$3,021,522	0.91%
16 COMBINED INSURANCE CO. OF AMERICA	\$2,793,424	0.84%
17 UNITED AMERICAN INS. CO.	\$2,758,867	0.83%
18 JOHN HANCOCK MUTUAL LIFE INS. CO.	\$2,612,540	0.78%
19 PROVIDENT LIFE & ACCIDENT INS. CO.	\$2,538,414	0.76%
20 LINCOLN NATIONAL LIFE INS. CO.	\$2,394,641	0.72%
21 CUNA MUTUAL INS. SOCIETY	\$2,624,780	0.79%
22 WASHINGTON NATIONAL INS. CO.	\$2,265,449	0.68%
23 PIONEER LIFE INS. CO. OF ILLINOIS	\$2,258,121	0.68%
24 NORTH CENTRAL LIFE INS. CO.	\$1,984,760	0.60%
25 NORTH AMERICAN LIFE AND CASUALTY	\$1,984,129	0.60%
26 UNIVERSE LIFE INS. CO.	\$1,963,762	0.59%

TOTAL: \$270,364,267 81.20%

TOTAL PREMIUMS PAID IN MT. IN 1989: \$332,940,480

SOURCE: MONTANA STATE AUDITOR'S OFFICE

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Jimi
PAQUETTE

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 3
DATE 2/7/91
BILL NO. SB 256

SAINT VINCENT HOSPITAL AND HEALTH CENTER
TESTIMONY IN FAVOR
OF THE
ANTI-DISCRIMINATION ACT

Saint Vincent Hospital and Health Center supports the PPO Anti-discrimination Act, SB 256. We want to emphasise that this legislation does not "outlaw" preferred provider arrangements or PPOs, but rather, insures that consumers, patients and businesses purchasing health care have access to hospitals, physicians, dentists, etc. who are willing to meet the terms and conditions set forth by either the purchaser or the insurance company representing the employer. The main point I want to make here is that the issue of maintaining access between consumers and those willing and able to contract with them to provide service is maintained. We would all agree that our objective is to keep health care costs down. There is nothing to insure that insurance companies are basing their contracting decisions on cost or quality under the current situation.

SB 256 could actually improve current preferred provider arrangements inasmuch as it will insure that health care consumers and providers such as physicians and hospitals, have

access to one another. A middleman such as Blue Cross cannot arbitrarily redirect business to the detriment of the consumer and/or employer. SB 256 will improve access for consumers and insure employers receive competitive rates.

The second point I want to make is that this type of law is necessary in a rural state such as Montana. Based on some of the testimony presented on January 9th, there seemed to be a focus on Billings and Yellowstone County, and in particular, hospitals. This issue affects all providers of health care and is even more important to the smaller communities in the state. In conversations with Senator Gary Yordy of Wyoming, the principal supporter of their Willing Provider legislation passed last year, he indicated that the bill passed easily in Wyoming - primarily because it is a rural state. As you know, it is very often difficult to recruit health professionals such as physicians, optometrists, dentists, etc. to practice in rural communities. With the potential threat of exclusive physician agreements, that recruitment will become even more difficult. As in Wyoming, because of Blue Cross/Blue Shield's sheer size, it maintains the ability to carve out physicians. Those excluded, unfortunately,

will be forced to abandon their practice in already under served rural areas. Senator Yordy said that Preferred Provider Arrangements are here to stay, so it is important that legislators focus on who they serve - and that is the consumer. By this legislation, we will insure that more Montanans may participate. In Wyoming, this legislation was essentially unopposed except by Blue Cross/Blue Shield.

Wyoming is not alone. Eleven (11) states have enacted "Anti-discrimination" or "Willing Provider" legislation, seven of which are rural in nature:

- Indiana
- New Hampshire
- Nebraska
- North Dakota
- New Mexico
- Utah
- Wyoming.

Why so many? In urban states or areas, there are many providers such as hospitals, physicians, dentists, etc., none of which dominate the market. The same is true of health insurance companies. In a state like Washington or Illinois, no insurance company dominates the market. Any provider can maintain exclusive agreements without threat to their continued existence.

Unfortunately, as the State of Wyoming recognized, that is not the make up of rural states such as Montana. Here, Blue Cross/Blue Shield, in figures released by the States Insurance Department for 1989, wrote commercial premiums totalling \$163 million out of a possible \$333 million, or approximately 50%. The second largest company wrote only \$12 million. A handout is included in my testimony which illustrates this point.

The third issue is cost. Opponents have argued that this legislation will cause costs to increase. As you heard on January 9, 1991, and will hear shortly by Blue Cross/Blue Shield and its allies, this legislation will cause health care costs to rise. This simply has not occurred in rural states with Anti-discrimination/Willing Provider statutes. Four out of the five rural states with Willing Provider laws, rank 41st, 46th, 47th and 48th in terms of per capita health care costs, easily among the lowest in the country. Even Indiana, with some large metropolitan areas, ranked 32nd. The point is that these laws do not drive up health care costs. In fact, health care spending in these states is very low compared to the remainder of the United States:

RANK

	<u>1980</u>	<u>1990</u>
Indiana	32	32
New Hampshire	43	41
New Mexico	49	46
Utah	47	47
Wyoming	48	48

Another argument heard over the last several weeks is that if this legislation is enacted, physicians and hospitals would have little incentive to enter into preferred arrangements and give discounts because other providers will be able to meet these conditions. The point being made is, what incentive do hospitals have to control their costs? Currently there are only nine states in the country with health care costs on a per capita basis lower than the State of Montana. We would submit to you that, through safeguards such as voluntary rate review, health care costs can be contained. The issue of providers not willing to participate in contracting is simply not true. Yellowstone County has two very good examples of that. Both the Billings School District #2 and the Indian Health Services have been able to secure favorable rates from both Billings hospitals.

Yellowstone County is a good example of two employers, Billings

School District #2 and the Indian Health Services, securing favorable rates from both Billings hospitals. These preferred provider arrangements have saved each of these organizations significant amounts on their health insurance costs. Both Indian Health Services and Billings School District #2 asked for and received discounted rates from both Billings hospitals. Neither were satisfied with just discounted rates; they wanted to preserve freedom of choice for their beneficiaries as well. That was a much more significant benefit: Savings coupled with choice. If approached on a reasonable basis, providers will willingly participate with employers to help them contain their health costs.

At the January 9, 1991 hearing, Randy Cline of Blue Cross/Blue Shield, said that the Deaconess Medical Center/Blue Cross/Blue Shield arrangement was made because Saint Vincent Hospital had an arrangement with Computer Claims Administration (d/b/a Employee Benefit Management Services). I am not sure what he meant by "arrangement", but I would like to clarify the situation.

Yellowstone County requested bids from third party administrators for rates on hospital services. Saint Vincent was asked by two

different TPA firms, Family Health Plan of Seattle and Consumer Claims Administration of Billings, for hospital rates for their respective bids. Saint Vincent Hospital allowed these TPA competitors to use its rates. At the outset, if Blue Cross/Blue Shield of Montana had asked for a Saint Vincent quote, the Hospital would have obliged them with the same rates.

A couple points need to be highlighted concerning Yellowstone County's bid. This was intended to be a response to one particular employer. This was not intended to be an ongoing, large, managed care program. The rates quoted were strictly for Yellowstone County - no one else. Second, Blue Cross/Blue Shield and Deaconess Medical Center teamed together for the same bid and, in fact, obtained the Yellowstone County employee contract. Mr. Cline's testimony that the Deaconess/Blue Cross managed care alliance, resulted from Saint Vincent's "arrangement" with Computer Claims Administration to bid for the Yellowstone County Contract, is erroneous. Family Health Plan also received rates from Saint Vincent Hospital to bid on Yellowstone County.

Once again, Saint Vincent Hospital recognizes the value of

Preferred Provider Arrangements, but, also recognizes the destructive capability of exclusive arrangements in rural states, particularly when one health service corporation is so large and so dominant. Such ability to direct health care through a PPO can be destructive to hospitals, physicians, both urban and rural, unless other willing providers are allowed to meet the PPO's terms and conditions.

Please support the Anti-discrimination legislation. It will protect Montana citizens' ability to choose the provider with which they are most comfortable, the provider in which their confidence has been well placed in the past. This legislation focuses on the "little guy" - not the insurance company that is so dominant within Montana that it can effectively direct patient care - direction that should be coming from the patient and the patient's physician. As a state, we need to recognize the wisdom in Wyoming's legislation which was designed to keep physicians in a rural state.

Thank you.

ACCIDENT AND HEALTH

K

INSURER

1989 DIRECT A & H

PREMIUMS WRITTEN IN MONTANA

BLUE CROSS/BLUE SHIELD OF MT.	\$162,957,526	48.94%
PRUDENTIAL INS. CO. OF AMERICA	\$12,481,653	3.75%
PRINCIPAL MUTUAL LIFE INS. CO	\$11,470,157	3.45%
CONTINENTAL ASSURANCE CO.	\$7,866,843	2.36%
BANKERS LIFE AND CASUALTY CO.	\$7,828,448	2.35%
MUTUAL OF OMAHA INS. CO.	\$5,675,593	1.70%
FEDERAL HOME LIFE INS. CO.	\$4,933,507	1.48%
STATE FARM MUTUAL AUTO INS. CO.	\$4,662,290	1.40%
JOHN ALDEN LIFE INS. CO.	\$4,600,358	1.38%
AETNA LIFE INS. CO.	\$4,429,966	1.33%
UNITED OF OMAHA LIFE INS. CO.	\$4,271,658	1.28%
TRAVELERS INS. CO.	\$3,349,172	1.01%
UNION BANKERS INS. CO.	\$3,324,206	1.00%
AETNA LIFE INSURANCE & ANNUITY CO.	\$3,312,481	0.99%
LIFE INVESTORS INS. CO. AMERICA	\$3,021,522	0.91%
COMBINED INSURANCE CO. OF AMERICA	\$2,793,424	0.84%
UNITED AMERICAN INS. CO.	\$2,758,867	0.83%
JOHN HANCOCK MUTUAL LIFE INS. CO.	\$2,612,540	0.78%
PROVIDENT LIFE & ACCIDENT INS. CO.	\$2,538,414	0.76%
LINCOLN NATIONAL LIFE INS. CO.	\$2,394,641	0.72%
CUNA MUTUAL INS. SOCIETY	\$2,624,780	0.79%
WASHINGTON NATIONAL INS. CO.	\$2,265,449	0.68%
PIONEER LIFE INS. CO. OF ILLINOIS	\$2,258,121	0.68%
NORTH CENTRAL LIFE INS. CO.	\$1,984,760	0.60%
NORTH AMERICAN LIFE AND CASUALTY	\$1,984,129	0.60%
UNIVERSE LIFE INS. CO.	\$1,963,762	0.59%

TOTAL: \$270,364,267 81.20%

TOTAL PREMIUMS PAID IN MT. IN 1989: \$332,940,480

SOURCE: MONTANA STATE AUDITOR'S OFFICE

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

RATE CONTROLS / SUPPLEMENT

an economic analysis service for healthcare management

VOLUME 14, NUMBER 12A

DECEMBER 15, 1990

Last month we discussed the report presented by two consumer groups, Families USA and Citizen Action. While the reports focused on a proposal for National Health Insurance, some of the supporting data was interesting and useful. Pages 5-7 are self-explanatory.

PER CAPITA HEALTH SPENDING

	1980 Amount	1980 Rank	1990 Amount	1990 Rank	2000 Amount
Massachusetts	1,284	1	3,031	1	6,890
California	1,186	4	2,894	2	6,584
New York	1,257	2	2,818	3	6,408
Nevada	1,109	8	2,757	4	6,272
Rhode Island	1,184	5	2,707	5	6,153
Connecticut	1,148	6	2,699	6	6,136
North Dakota	1,066	12	2,661	7	6,051
Illinois	1,093	11	2,619	8	5,953
D.C.	1,241	3	2,586	9	5,882
Michigan	1,097	10	2,569	10	5,840
Missouri	1,033	16	2,568	11	5,837
Kansas	1,057	13	2,548	12	5,792
Pennsylvania	1,021	17	2,536	13	5,763
Ohio	1,039	15	2,493	14	5,667
Minnesota	1,110	7	2,480	15	5,641
Hawaii	993	20	2,469	16	5,619
Nebraska	1,016	18	2,452	17	5,576
Wisconsin	1,097	9	2,449	18	5,567
Maryland	1,041	14	2,436	19	5,541
Florida	962	22	2,427	20	5,520
Colorado	996	19	2,415	21	5,496
Alaska	921	31	2,367	22	5,390
Iowa	993	21	2,351	23	5,343
South Dakota	952	24	2,322	23	5,278
Oregon	940	26	2,312	25	5,260
Washington	929	29	2,311	26	5,258
Alabama	924	30	2,286	27	5,201
Delaware	960	23	2,268	28	5,160
Tennessee	952	25	2,262	29	5,145
New Jersey	930	28	2,224	30	5,056
Arizona	848	39	2,211	31	5,031
Indiana	919	32	2,201	32	5,004
Texas	915	33	2,192	33	4,987
Louisiana	940	27	2,185	34	4,972
Maine	870	36	2,175	35	4,945
Oklahoma	906	34	2,139	36	4,867
West Virginia	843	41	2,088	37	4,752
Virginia	863	37	2,076	38	4,724
Georgia	883	35	2,072	39	4,714
Montana	859	38	2,059	40	4,686
New Hampshire	813	43	1,981	41	4,505
Vermont	815	42	1,956	42	4,448
Arkansas	844	40	1,944	43	4,423
Kentucky	806	44	1,875	44	4,266
North Carolina	773	45	1,833	45	4,170
New Mexico	711	49	1,792	46	4,078
Utah	741	47	1,784	47	4,062
Wyoming	714	48	1,756	48	3,996
Mississippi	759	46	1,751	49	3,984
Idaho	708	50	1,726	50	3,928
TOTAL	\$1,016		\$2,425		\$5,515

Amendments to Senate Bill No. 256
First Reading Copy

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 4

DATE 2/7/91

BILL NO. SB256

Requested by Senator Lynch
For the Committee on Business and Industry

Prepared by Bart Campbell
February 5, 1991

1. Title, line 8.

Following: "AMENDING"

Strike: "SECTION"

Insert: "SECTIONS 33-22-1702 AND"

2. Page 2, line 24.

Following: line 23

Insert: "Section 2. Section 33-22-1702, MCA, is amended to read:

"33-22-1702. Purpose -- legislative finding. (1) The legislature finds that the health and welfare of all Montanans is significantly influenced by the availability of affordable health care services and the delivery of those services. The legislature further finds that the state has compelling interests in preventing preferred provider agreements from discriminating against other willing providers and in assuring that willing providers be given the opportunity to meet the terms and conditions of established preferred provider agreements.

(2) The purpose of this part is to allow a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to:

(1)(a) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or

(2)(b) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan."

Renumber: subsequent section

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 5DATE 2/7/91BILL NO. SB 256

Blue Cross and Blue Shield of Montana

1988	Form 13 Blue Cross and Blue Shield of Montana Total Premium Earned	\$141,809,972	
	Less Administrative Service Contracts	(\$ 28,132,206)	
	National Accounts	(\$ 868,274)	
		<u>\$112,809,492</u>	43.1%

1988	Total Commercial Insurers Premium Earned	<u>\$148,717,396</u>	56.8%
		\$261,526,888	

339 Commercial Carriers wrote business during 1988 in Montana.

1989	Form 13 Blue Cross and Blue Shield of Montana Total Premium Written	\$162,957,526	
	Less Administrative Service Contracts	(\$ 29,535,117)	
	National Accounts	(\$ 386,871)	
		<u>\$133,035,538</u>	44%

1989	Total Commercial Insurers Premium Written	<u>\$169,982,954</u>	56%
		\$303,018,492	

The 1988 figures were derived from the Montana Comprehensive Health Care Association assessment calculation. The last assessment made was December 1989 based on 1988 premium volume information from the offices of the State Auditor and the Commissioner of Insurance.

Premium volume reflected on Blue Cross and Blue Shield annual statements filed with the Insurance Department reflects underwritten business and self-funded groups for which we provide claims administration (administrative service contracts). Premium volume for commercial insurers does not reflect administrative service contract groups.

The 1989 total commercial insurance premium written figure was received from the Montana Insurance Department.

BLUE CROSS AND BLUE SHIELD OF MONTANA

MEMORANDUM

February 6, 1991

Some TPA and Self-Insured Groups Identified by District:

Missoula

St. Patrick Hospital
Washington Corporation
City of Missoula
Missoula County
Zip Beverage
Missoula Electric

Butte

Western Energy
Twin Bridges School
Dillon School District
St. James Hospital
Montana Resources
Madison County
Butte/Silver Bow
AASCO Foundry

Great Falls

Deaconess Medical Center
Columbus Hospital
Lewistown Hospital
MAIDS
Hill County
Blaine County
Choteau Schools
Sun River Schools
Pacific Hide and Fur
Great Falls Gas Co.
D.A. Davidson
Havre Clinic

Miles City

Colstrip Schools
First Security Bank Miles
Custer County
Glendive Memorial Hospital
Francis Mahon Hospital
Plevna Schools
Bainville School

Miles City (cont.)

Rosebud County
Rosebud County Hospital
Glasgow School District
Wolf Point School District
Plentywood School District

Billings

Conlins Furniture
Molerway Freight Lines
Beal Mfg.
MAIDS
IBEW Electricians Trust
Montana Contractors, Statewide
Henry's Safety Supply
Bighorn County
Musselshell County
Melstone Schools
Roundup Schools
Columbus Schools
Bob's Supermarkets
St. John's Nursing Home
Cenex Refinery
City of Billings
Billings School District
Montana BancSystems
Rocky Mountain BancSystems
Roscoe Steel
Coke West
Deaconess Medical Center
Billings Medical Center
Waggoner Trucking

Bozeman

Bozeman Deaconess Hospital
Gallatin County
Sweet Grass County
Belgrade Schools
Bozeman Schools

Helena

State of Montana
Montana Power Co.
Lewis and Clark County
Broadwater County
Jefferson County

Helena (cont.)

IBM

Helena School District
Townsend School District
Clancy School District

Kalispell

Kalispell Regional Hospital
Semitool, Inc.
St. John's Lutheran Hospital
Flathead County
Pacific Power
N.W. Telephone
Columbia Falls Schools
Libby School District
Noxon Schools
Sanders County
Lincoln County High School
Salish and Kootenai College
Outlaw Inn
Arlee School Charlo School
Timber Trust Oregon

TA/smp
D051P

February 7, 1991

SENATE BILL 256

BEFORE SENATE BUSINESS & INDUSTRY

Testimony of David Hartman
Montana Education Association

Senate Bill 256 would effectively eliminate preferred provider (PPO) agreements in Montana between employers/employees and health care providers. It would eliminate the "preferred" in PPO's by requiring that the terms of these agreements be open to all health care providers willing to meet the terms of the agreement as to charges for services.

PPO's have become increasingly popular because they may help to control escalating costs of health care services. Health care providers are willing to discount the cost of their services because they are being guaranteed a block of business from an identified employee group.

By giving other health care providers equal access to this block of business, the incentive for discounted rates has been destroyed. SB 256 will see the end of PPO's in Montana and add to the inflationary spiral in health care costs. It will unfairly restrain efforts by employers and employee groups to control health care costs and their expenditures for health care services.

School districts and school employees in both Missoula and Billings currently participate in PPO arrangements with selected health care providers. The group health insurance programs in these two school districts are self-insured. Neither Blue Cross-Blue Shield nor any other insurance company has a stake in these programs.

PPO's are one approach which employers and employees have used in efforts to control escalating health care costs and the costs of health insurance premiums or contributions.

The cost of health care and insurance for health care is the result of three forces: Cost of services x quantity of service x type or quality of service. PPO arrangements give employers and employee groups the opportunity to address the first force: Cost of service.

Hundreds of PPO's now operate nationwide, including several in Montana. I urge the Committee to continue permitting employers and employee groups to explore ways of controlling health care costs and the costs of health insurance premiums or contributions. I urge your "Do Not Pass" action on SB 256.

ACCIDENT AND HEALTH

Rank	Insurer	1989 Direct A & H Premiums Written in MT
1.	Blue Cross/Blue Shield of MT	\$162,957,526
2.	Prudential Ins. Co. of America	12,481,653
3.	Principal Mutual Life Ins. Co.	11,470,157
4.	Continental Assurance Co.	7,866,843
5.	Bankers Life and Casualty Co.	7,828,448
6.	Mutual of Omaha Ins. Co.	5,675,593
7.	Federal Home Life Ins. Co.	4,933,507
8.	State Farm Mutual Auto Ins. Co.	4,662,290
9.	John Alden Life Ins. Co.	4,600,358
10.	AEtna Life Ins. Co.	4,429,966
11.	United of Omaha Life Ins. Co.	4,271,658
12.	Travelers Insurance Co.	3,349,172
13.	Union Bankers Ins. Co.	3,324,206
14.	Life Investors Ins. Co. of America	3,021,522
15.	Combined Insurance Co. of America	2,793,424
16.	United American Ins. Co.	2,758,867
17.	John Hancock Mutual Life Ins. Co.	2,612,540
18.	Provident Life & Accident Ins. Co.	2,538,414
19.	Lincoln National Life Ins. Co.	2,394,641
20.	Cuna Mutual Ins. Society	2,324,780
21.	Washington National Ins. Co.	2,265,449
22.	Pioneer Life Ins. Co. of Illinois	2,258,121
23.	North Central Life Ins. Co.	1,984,760
24.	North American Life and Casualty	1,984,129
25.	Universe Life Insurance Co.	1,963,762

PIERCE

FLOORING & DESIGN CENTER

February 7, 1991

Senator Betty Bruski
Committee on Business and Industry
Montana Senate
Capitol Station
Helena, Montana 59620

Senate Business & Industry
Exhibit 7
Date 2/7/91
Bill no. SB256

Dear Ms. Bruski:

For the record, I am part owner of Pierce Flooring, Pierce Mobile Homes, and the Carpet Barn. I manage the two floor covering operations. We provide health insurance benefits to ninety-one (91) employees plus many of their dependants.

In July of 1990, we elected to participate in the HealthLink program provided by Blue Cross/Blue Shield in order to contain the ever-increasing costs of providing health insurance benefits. Yes, we were able to contain some of our health care costs but there were problems incurred that were not foreseen. The doctor/patient relationship is very important. By requiring our employees to do business with one provider, we have disrupted some of those relationships; or have made them pay a higher rate. Some employees have never been to, nor have they received care by the Deaconess Hospital. Because of our decision, we have forced them to change hospitals. In some cases it required the transfer of medical records from one hospital to the other. These are a few of the problems we didn't think of when we made our decision. Employees understand our rationale but some are unhappy.

Ms. Bruski, presently the HealthLink program affects only those employees our Billings stores. I am certain in the near future we will be addressing the Preferred Provider Organizations in our other outlets in Bozeman, Missoula and Great Falls. Ms. Bruski, I urge you to support SB256 to revise PPO agreements so that they are available to willing providers. It would provide Pierce employees the opportunity to choose the hospital of their choice.

Sincerely,
PIERCE FLOORING & DESIGN CENTER

G. Ron Pierce
G. Ron Pierce
President

GRP/ps

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 7th day of February, 1991.

Name: Jim Oquette

Address: 1109 Toole Ct.

Billings 59105

Telephone Number: 406-252-6117

Representing whom?

SAINT Vincent Hospital

Appearing on which proposal?

SB 256

Do you: Support? L Amend? Oppose?

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

2/7/91

BUSINESS & INDUSTRY

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
Pat Melby	Pinrock Foundation	SB256	✓	
Wendy [unclear]	Pinrock Fdn	SB256	✓	
Jim [unclear]	SAINT VINCENT HOSP	SB256	✓	
MARK A. BURZYNSKI	SAINT VINCENT HOSP	SB256	✓	
BOB B. DOOLEY	DOXOWESS MCD CONDO	SB256	✓	✓
LARRY D. WILLIAMS	GT FALLS S.D. #1 & A	SB256	✓	X
Steve Brown	Blue Cross - Blue Shield	SB256		✓
Tom L. Hamlin	Private Rural Practice	SB256	✓	
LARRY MCGOVERN	MOUNT ABIE Phys.	SB256	✓	
Les [unclear]	St Vincent Hospital	SB256	✓	
Lucy Ham		SB256	✓	
Bunnie Warwood	Leadership Great Falls			
Doug Olson	" "			
Red Robinson	Leadership G Falls	SB256	✓	
Robin Castle	" " "	SB256	✓	
DALE HOFFMAN	HOFFMAN ASSOC.			✓
Tim Carlson	BC/BS of MT	SB256		✓
Tom Hoggard	Health Ins Assoc Amel.	SB256		✓
Ziggy Ziegler	Gellatone CO	SB256		✓
DAVID HARTMAN	MEA	SB256		✓
Les [unclear]	mt. food assoc	SB256	✓	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	SB256		X
CARL HANSON	Adm. Pondera Medical Center	SB256	✓	
Dave Barnhill	Insurance dept	SB256	✓	
Mimi [unclear]	Rocky Mt. Insur. Assn	SB256	✓	
Ann Bellwood	Rocky Mt. Insur. Assn	SB256	✓	

Business & Industry

[illegible]

100-443887-100

The motion to table passed by a 5 to 4 vote.

EXECUTIVE ACTION ON SENATE BILL 256

Motion:

Senator Gage moved to pass the amendments for SB 256.

Senator Williams moved to do pass SB 256.

Discussion:

Senator Thayer stated that he would resist the motion to pass SB 256, the bill essentially says that if the committee passes this that the legislature is not interested in bringing down costs of healthcare in Montana. There is no need for the additional language in the bill, and he would resist the amendment.

Senator Noble stated that he found it interesting that the company that is offered the preferred provider option, the employees that have the option to take it or not take it. They have the option to take it, and get a discount on their insurance, or to not take it and go wherever it is they want to go.

Senator Lynch stated that the blues have doctors that sign up and then they are listed as one of the blue's doctors under that plan, but every doctor has a chance to sign up. They are given an equal opportunity. The hospitals do not have that option. This bill is giving the hospitals the same options to sign up just like the doctors.

Senator Franklin stated that there is an individual level in terms on how you might be concerned about individual premiums, then there is a larger picture that speaks to the fragility of health agencies that we're in, and the healthcare system.

Senator Bruski stated that if the hospitals can afford this twenty five percent discount to preferred providers, why can't they offer a discount to all of their services.

Senator Lynch asked if of the eleven states that have passed legislation on this, there is not one PPO in any one of them. Wyoming eliminated any PPO in Wyoming, are they absolutely gone.

Dave Barnhill stated that it doesn't eliminate PPO by passing this legislation.

Amendments, Discussion, and Votes:

Bart Campbell went over the amendments (See Exhibit 3). The language is saying that because there are legislative findings that the state has compelling interests in preventing against preferred provider agreements from discriminating against willing providers, and to ensure that the willing providers be given the opportunity to meet the terms that the legislature will establish that any willing provider can enter into the preferred provider agreement.

Senator Lynch asked what would happen if this language was not in the bill.

Bart Campbell stated that this language almost like a whereas, it is really like a description of intent. If it weren't in the bill, it wouldn't effect the bill.

Senator Thayer stated that it is very substantive.

Recommendation and Vote:

The amendments to SB 256 failed 5 to 4 votes.

SB 256 do passed on a 5 to 4 vote.

HEARING ON HOUSE BILL 16

Presentation and Opening Statement by Sponsor:

Representative Jerry Driscoll, house district 92 in Billings, sponsor of the bill, stated that this bill requires that all printing done in the state of Montana by the lowest responsible bidder; providing that if there is no responsible in-state bidder, the work may be performed by the lowest responsible bidder outside the state. The bill will strengthen the printing industry in Montana, and the printer will be able to buy some of the equipment that they need to be further into the industry of printing. The fiscal note says that it will cost more money, but in effect if they do their job right we'll get less printing.

Proponents' Testimony:

Chuck Walk, executive director of the Montana newspaper association, spoke in favor of the bill. It addresses the immediate need for Montana printers to become more competitive with larger out of state providers in obtaining printing work from our own state government. It could be an important factor in the future development in rebuilding of a printing industry in the state that is admitted trouble. If it encourages one Montana printer to buy a new piece of equipment and hire one or two more employees, that he might not have done without this legislation, it would have served a worthwhile purpose. It would eventually result in more in state printers obtaining and enlarging there operations to become competitive with each other, instead of advocating business to out of staters it will be considered a model piece of economic development legislation.

Christian Macka, on behalf of Don Judge representative of Montana state AFL-CIO, spoke in support of house bill 16 (See Exhibit 4).

Bob Hiser, on behalf of the united workers union, spoke in favor of the bill. Montana tax dollars should be spent in Montana if at all possible. This bill has the potential of providing jobs in Montana.

Opponents' Testimony:

ROLL CALL

Business & Industry COMMITTEE

DATE 2/15/91

LEGISLATIVE SESSION

NAME	PRESENT	ABSENT	EXCUSED
Senator Bruski	X		
Senator Franklin	X		
Senator Gage	X		
Senator Hager	X		
Senator Noble	X		
Senator Thayer	X		
Senator Williams	X		
Senator Kennedy	X		
Senator Lynch			

Each day attach to minutes.

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/15/91 Bill No. SB 252 Time 10:00

NAME	YES	NO
Senator Bruski	✓	
Senator Franklin	✓	
Senator Gage		✓
Senator Hager		✓
Senator Noble		✓
Senator Thayer		✓
Senator Williams	✓	
Senator Kennedy		✓
Senator Lynch	✓	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: TO PASS AMENDMENTS

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/15/91 Bill No. SB256 Time 10:00

NAME	YES	NO
7 Senator Bruski	X	
6 Senator Franklin	X	
5 Senator Gage		X
4 Senator Hager		X
3 Senator Noble		X
2 Senator Thayer		X
1 Senator Williams	X	
8 Senator Kennedy	X	
9 Senator Lynch	X	

Dara Anderson

Secretary

JD Lynch

Chairman

Williams
Motion:

Do Pass

Amendments to Senate Bill No. 256
First Reading CopyRequested by Senator Lynch
For the Committee on Business and IndustryPrepared by Bart Campbell
February 5, 1991

1. Title, line 8.

Following: "AMENDING"

Strike: "SECTION"

Insert: "SECTIONS 33-22-1702 AND"

2. Page 2, line 24.

Following: line 23

Insert: "Section 2. Section 33-22-1702, MCA, is amended to read:

"33-22-1702. Purpose -- legislative finding. (1) The legislature finds that the health and welfare of all Montanans is significantly influenced by the availability of affordable health care services and the delivery of those services. The legislature further finds that the state has compelling interests in preventing preferred provider agreements from discriminating against other willing providers and in assuring that willing providers be given the opportunity to meet the terms and conditions of established preferred provider agreements.

(2) The purpose of this part is to allow a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to:

(1)(a) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or

(2)(b) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan."

Renumber: subsequent section

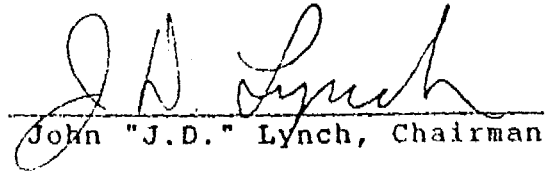
SENATE STANDING COMMITTEE REPORT

Page 1 of 1
February 15, 1991

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill No. 256 (first reading copy -- white), respectfully report that Senate Bill No. 256 do pass.

Signed: _____


John "J.D." Lynch, Chairman

141 2-15-91
And. Coord.

SB 2-18-91 3:25
Sec. of Senate

1 *Sen. Bill NO. 256*
 2 INTRODUCED BY *Sen. Lynch*
 3
 4 A BILL FOR AN ACT ENTITLED: "AN ACT AMENDING THE PREFERRED
 5 PROVIDER AGREEMENTS ACT TO REQUIRE HEALTH CARE INSURERS TO
 6 ENTER INTO PREFERRED PROVIDER AGREEMENTS WITH ALL HEALTH
 7 CARE PROVIDERS WILLING TO PROVIDE HEALTH CARE SERVICES UNDER
 8 A PREFERRED PROVIDER AGREEMENT; AMENDING SECTION 33-22-1704,
 9 MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

10
 11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

12 **Section 1.** Section 33-22-1704, MCA, is amended to read:

13 "33-22-1704. Preferred provider agreements authorized.

14 (1) Notwithstanding any other provision of law to the
 15 contrary, a health care insurer may:

16 (a) enter into agreements with providers relating to
 17 health care services that may be rendered to insureds or
 18 subscribers on whose behalf the health care insurer is
 19 providing health care coverage, including preferred provider
 20 agreements relating to:

21 (i) the amounts an insured may be charged for services
 22 rendered; and

23 (ii) the amount and manner of payment to the provider;
 24 and

25 (b) issue or administer policies or subscriber

1 contracts in this state that include incentives for the
 2 insured to use the services of a provider that has entered
 3 into an agreement with the insurer pursuant to subsection
 4 (1)(a).

5 (2) A health care insurer shall establish terms and
 6 conditions to be met by providers wishing to enter into an
 7 agreement with the health care insurer under subsection
 8 (1)(a). These terms and conditions may not discriminate
 9 against or among providers. For the purposes of this
 10 subsection, price differences among hospitals or other
 11 institutional providers produced by a process of individual
 12 negotiation or by price differences among different
 13 geographical areas or different specialties do not
 14 constitute discrimination. A health care insurer may not
 15 deny a provider the right to enter into an agreement under
 16 subsection (1)(a) if the provider is willing to meet the
 17 terms and conditions established in that agreement.

18 (2)(3) A preferred provider agreement issued or
 19 delivered in this state may not unfairly deny health
 20 benefits for health care services covered.

21 (3)---This---part---does---not---require---that---an---insurer
 22 negotiate---or---enter---into---agreements---with---any---specific
 23 provider---or---class---of---providers---"

24 NEW SECTION. Section 2. Effective date. [This act] is
 25 effective on passage and approval.

-End-
 -2-

THIRD READING

58 256

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on March 19, 1991,
at 3:00 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Stella Jean Hansen (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Bill Strizich (D)
Rolph Tunby (R)

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

HEARING ON SB 256

Presentation and Opening Statement by Sponsor:

SEN. JOHN "J.D." LYNCH, Senate District 34, Butte, stated that this bill was originally part of an insurance commissioners cleanup to SB 16. The largest health provider in the State of Montana, Blue Cross & Blue Shield (BCBS), has around 50% of all of the business of insurance. BCBS made an agreement with one hospital and excluded the agreement with this hospital in Billings without ever contacting the other hospitals. BCBS said if you sign the agreement then BCBS will give you a discount. BCBS will guarantee that every single person covered by BCBS will come to your office and will hurt the other offices. The

availability of service is threatened by the present operations of PPOs in the state. They could make the same agreement with the drug stores and they could make the same agreement with the local hospitals. The costs are lower in rural hospitals than they are in the larger hospitals. The truth is that if the costs would have been lower at another hospital had they been to the hospital, but BCBS made the deal with the other hospital in Billings. They are not worried about the lower cost. The opponents will say that this should be done because other states really aren't doing that. The most recent example is the state of Wyoming. The issue is about fairness and having an equal opportunity. This idea of exclusive discount only to one hospital is anything but fair. This bill does not gut PPOs.

Proponents' Testimony:

James Ahrens, Montana Hospital Association, submitted written testimony. EXHIBIT 1

Jim Poquette, President, Saint Vincent Hospital and Health Center, submitted written testimony. EXHIBIT 2

Joel Lankford, Vice President, Columbus Hospital, stated that SB 256 will not drive up costs for health care. Columbus Hospital has its own insurance plan. In 1989 the ratio raised 6%, but the whole cost of the plan went up 25%. The point of this whole issue is that we are not talking about cost control, we are talking about this bill. Regardless of the existence of providing this bill, the hospitals of Montana are more than interested in seeing this bill and finding out what is available. The real issue is public policy. The central issue is the exercise of monopolistic powers by a certain business in our state. Is it good public policy to allow insurance companies to punish providers for management decisions. Is it good public policy to allow a provider to monopolize in marketing in conjunction with the insurer for the death of a provider. We will set up an exclusive PPO with a monopolistic power, BCBS, they have half of the business of people that actually pay their bills.

Joseph Hanser, Banking Industry, Self, stated that in Montana's existing situation, the PPO does not provide for a competitive rate structure. It provides for enhancement of quality health services. In the long run it will have a detrimental effect of both. The arrangement was not competitively bid or negotiated by two parties. They will impact the quality of health service primarily in the event that myself or family were to receive an intention from the preferred provider, our only alternative is to incur the financial penalty to going to one of the competition. Outside of incurring that financial penalty, our only other course would be to write letters to the insurance company or to the provider, which from his perspective would have real effect. If the present situation continues to go unchecked, this would allow for a monopoly relation of the health care services and

deterioration of the quality of health services in communities served by PPOs. If you recommend the support to this bill that all providers can compete on an equal basis for the business in the community, the rates established by the PPOs would be competitive with the experience of the group insured plan. The existence of the PPO could actually be enhanced in that they would have the opportunity to the group insurance plan and solicit their business. They could obtain the information from the insurance company on the demographics of the group. The preferred provider could then offer to the group number maintenance health services, enhance medical services, follow up services, or user discounts. This would be a much more beneficial situation than to have a financial penalty.

Jerry Jerina, Administrator, Trinity Hospital, Wolf Point, stated that he fears exclusive contracts when he doesn't have a chance to participate. In Montana there are 50 hospitals in communities by themselves who are not competing with anybody but each other. If exclusive contracts are allowed in the state, we are going to start limiting access to the rural hospitals. When we start taking business away from each other in rural areas, sooner or later the hospital that we took business away from is no longer going to survive. When we have limited access to health care, how far are we going to have to drive for primary care.

David Cunningham, Director, Rimrock Foundation, submitted written testimony. EXHIBIT 3

Mike Rupert, President Chemical Dependency Programs of Montana, Executive Director, Boyd Andrew Chemical Dependency Care Center, stated that the real issue in this bill is do we want to allow the insurance industry to dominate and dictate the entire health care industry in the state. One argument they will present is that this bill will negate the positive financial benefits for PPOs. This makes no sense, if there are two hospitals in Billings, and one has this arrangement the other will go out of business. If you only have one health care provider in Billings, that is conducive to lower costs. If you have three providers all providing a set fee, the net effect when the contracts are negotiated, is the prices went down. This bill will lower health care costs.

Bob Jones, Wheatland Memorial Hospital and Nursing Home, submitted written testimony. EXHIBIT 4

Candice Sellers, President, Family Health Plan, Inc., submitted written testimony. EXHIBIT 5

Barry Kingfield, Executive Vice President, Community Medical Center, Missoula, stated that they support SB 256.

Dave Barnhill, Deputy, Insurance Commissioner, stated that they support the bill.

John Delano, Montana Medical Association, stated that they are in favor of SB 256 without amendments.

Opponents' Testimony:

SEN. DELWYN GAGE, Senate District 5, stated that he was originally the sponsor of this bill. We are aware of what is happening with the PPO situation in saving people money on their insurance premiums. We don't know what will happen if we change that. We are proposing amendments, as were proposed in the Senate. St. Vincent Hospital indicated that they weren't asked about the PPO arrangement and that the other hospital did have the opportunity. If you go into an area and there is more than one provider, each provider has the opportunity to participate in a PPO proposal.

Cal Winslow, Deaconess Medical Center, stated that the preferred provider arrangements under the present statute provides competitive prices. That in fact, is something that the state has interment appropriate. That is why you have the statutes presently. HMOs will never work in the State of Montana because of our rural nature and PPOs are only going to work in some areas because of the employers basis in those areas. This works in a competitive environment and does provide an opportunity to provide for competitive prices. If you do not want that, that is what this legislation does. Of the results of the PPO in place today, 15% discounts the premiums for those industries that buy health insurance for their employees, which is 50% less. There are 180 groups that are now in Montana health care, they are all in Yellowstone County. 130 of those groups of employers have less than 10 employees. The few dollars that they can save in health care premiums are substantial in keeping the business afloat. The proponents say that with open access, PPOs will work. Discounts are given because of marketship, if there is no marketship, there is no incentive to have any discounts, and there won't be any discounts. Deaconess Medical Center is happy to compete in whatever environment this legislature feels is best for Montana. Please be clear that if this PPO is, in fact, the desire of the Legislature to do away with, the other kinds of arrangements between hospitals and providers are also done away with. Good health care is important to all Montanan's. Lets stop start passing legislation that gives it direction so Montana can continue to go forward in some direction to provide the best kind of health care at a reasonable rate.

Steve Brown, Blue Cross & Blue Shield (BCBS), stated that PPOs do work and do provide significant savings to the health insurance consumer. The unfortunate thing about the existing PPO is that we have been unable to give those PPOs some distance in the other working areas in the state. Both hospitals in Missoula declined to enact a PPO agreement that would result in significant savings to the health insurance consumers. Ask the people who pay health insurance bills, ask the employers who are buying health insurance for their employees, whether they prefer PPO

arrangements. The first PPO agreement in Billings contains a penalty for members of that PPO if they go to another hospital. When they stand there and say that it is bad for Deaconess and BCBS to use that kind of incentive to get people to take their business to Deaconess, on the very first page it declines St. Vincent's PPO agreement, a similar penalty provision. He submitted amendments. EXHIBIT 6

Tom Hopgood, Health Insurance of America, submitted written testimony. EXHIBITS 7 & 8

Dick Fellows, First Interstate Bank System of Montana (FIBS), stated that his organization owns and operates seven banks in Montana and employs approximately 500 people in the state, half of which reside in Yellowstone County. In July 1990, FIBS accepted a preferred survivor arrangement with the Deaconess Medical Center in Billings that was offered in part with BCBS group health plan for employees residing in Yellowstone County. This PPO arrangement will save our employees and organization approximately \$80,000 in premiums during the first year of this arrangement. This is only half of our employees in the state. We fully expect a similar decrease in our claims experience in the same period. As is the case with many employers in Montana, we have experienced significant increases in the cost of our group health plan during the past few years. Initially, we address these increases by shifting some of the cost to our employees through higher deductibles, higher out of pocket limits and decreased plan benefits. We recognize the burden that is placed on employees, as a result, we began to review more innovating approaches that control our health plan costs. Our PPO arrangement along with other costs contained provisions of our insurance contract and are very important to us as employers in controlling the cost of our benefit plan. As employers, we prefer not to limit the choice of our employees in selecting health care providers, but we are realistic and understand that this choice has a cost. When FIBS first viewed the PPO arrangement that was offered by BCBS, we asked that our employees outside of Yellowstone County not be included because of our concern with rural hospitals. BCBS indicated that the PPO option, with the Deaconess Medical Center in Billings, would not be available outside of Yellowstone County. The survival of these rural hospitals is important to FIBS since we have banks in three of these small communities. We feel it would be a serious mistake restricting the abilities of employees in Montana to work with insurance companies in negotiating contracts with health care providers. This proposed legislation would not directly eliminate the ability of insurance companies to negotiate PPO contracts, but would merely allow any other willing provider to match the terms and conditions of a negotiated PPO agreement. As a practical matter, it is unlikely that a PPO agreement would be consummated because the health care provider in this case, would not be insured of any volume of business to offset price concessions that would be made. Without this legislation, each provider has the option and the opportunity to negotiate with

employers and insurance carriers on their own PPO arrangements. It is not appropriate that the government could limit the ability to negotiate and contract in order to better control significant contracts for many employers of Montana.

David Hartman, Montana Education Association, submitted written testimony. EXHIBIT 9

James Tutwiler, Montana Chamber of Commerce, stated that the Chamber strongly opposes this bill.

Gorden Englert, Risk Manager, Yellowstone County, stated that we do need competition in our state.

Joyce Brown, Chief of Employee Benefits Bureau, Department of Administration, submitted written testimony. EXHIBIT 10

Terry Mammenga, Tractor & Equipment Co., Billings, stood in opposition of this bill.

Gary Richard, Self, Billings, stood in opposition of this bill.

Questions From Committee Members:

REP. BOHARSKI asked why the insurance commissioner is in support of this bill. Mr. Barnhill stated that the Preferred Provider Act was enacted by the Montana Legislature in 1987. This act was added after a National Association of Insurance Commissioners model law. This contains a willing provider statute. This statute provided that in setting up a PPO insurer or health service corporation. We had to give due consideration to the cost of health services, the availability of health services and also the quality of health services. Montana law specifically authorized health insurers and health service corporations to pick and choose any provider with whom they wanted to do business without any criteria. This does not require that an insurer negotiate or enter into an agreement with any specific provider or any class of providers. Thus, under current law, an insurer can choose a provider whose services are inferior to those of other providers.

REP. BOHARSKI asked if there was an act of consideration given to the quality of health care and the availability of health care. Mr. Barnhill said no. The National Association of Insurance Commissioners model law contained that the states might consider a stronger willing provider statute. The stronger provision is pertinent to Montana because a preferred provider is accredited upon the provider receiving increased volume of business in return for acceptance of lower payment of fees. This would work in a heavily populated state or where the state has growing population.

REP. SQUIRES asked if both of the hospitals in Missoula had the privilege of bidding or discussing PPOs. Mr. Kingfield stated

that they were offered an opportunity to discuss this with BCBS. In those discussions they were offered exclusive preferred buyer arrangement. They were not interested in this at that time. Mr. Hogan stated that they were never contacted by BCBS. As soon as it was announced he called BCBS and told them they were willing to read the terms and conditions of the contract and BCBS indicated that they wouldn't be able to do it.

REP. SPRING asked if the two hospitals in Billings get the same break. Mr. Poquette said no.

REP. STRIZICH asked what the effect the amendments would have on the willing provider provision of the bill and what effect do they have on the selection and criteria. Mr. Enzerie stated that the first amendment states "unfairly discriminate", which you either you discriminate or you don't. The willing provider language, which is the heart of the bill has been deleted under these amendments. You do not have the right to meet the same terms and conditions. There is some criteria about bidding, but it doesn't indicate that you have to take the lowest bid. At the end of the bill, there is a new section on insured and that looks like an arrangement where you get to let BCBS play. In looking at the title of the bill, it looks like something that wasn't contemplated.

REP. JOHNSON asked what is the number of people involved in the PPO. Mr. Butler stated that approximately 6,500 consumers of the BCBS Deaconess PPO in Billings.

REP. JOHNSON asked if the total number of consumers might be in the same area that would be insured in some other area. Mr. Barnhill stated that there approximately 100,000 people in the Yellowstone County area. Then you can break them down in terms of Medicare, Medicaid, Indian Health Services, BCBS, commercial health insurance, and no insurance.

Closing by Sponsor:

REP. LYNCH stated that this is more than just looking at things. The bill is in good shape. Hi is not in the middle of the squabble in Billings, this goes far beyond the city limits of Billings and far beyond hospitals. This PPO provision is willing to provide for such things as chemical dependency centers. The deal will be made with one business and the operations will be that others are completely shut. This bill is intact and it should be passed as is.

HEARING ON HB 978

Presentation and Opening Statement by Sponsor:

REP. JOHN PHILLIPS, House District 33, Great Falls, stated that this bill is asking SRS to allow Medicaid patients to reside in personal care services. If you have a Medicaid patient moving

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL

DATE 3-19-91

NAME	PRESENT	ABSENT	EXCUSED
REP. ANGELA RUSSELL, CHAIR	✓		
REP. TIM WHALEN, VICE-CHAIR	✓		
REP. ARLENE BECKER	✓		
REP. WILLIAM BOHARSKI	✓		
REP. JAN BROWN	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. PATRICK GALVIN	✓		
REP. STELLA JEAN HANSEN	✓		
REP. ROYAL JOHNSON	✓		
REP. BETTY LOU KASTEN	✓		
REP. THOMAS LEE	✓		
REP. CHARLOTTE MESSMORE	✓		
REP. JIM RICE	✓		
REP. SHEILA RICE	✓		
REP. WILBUR SPRING	✓		
REP. CAROLYN SQUIRES	✓		
REP. JESSICA STICKNEY	✓		
REP. BILL STRIZICH	✓		
REP. ROLPH TUNBY	✓		



MONTANA HOSPITAL ASSOCIATION

EXHIBIT _____
DATE 3-19-91
SB 256

1720 NINTH AVENUE • PO BOX 5119
HELENA, MT. 59604 • (406) 442-1011

**Testimony by
James F. Ahrens, President
Montana Hospital Association
before the House Human Services & Aging Committee
March 19, 1991**

The Montana Hospital Association supports SB 256.

MHA supports this bill because of our concern about the impact of PPOs on the availability of health care services in Montana's small communities.

All of us are concerned about rising health care costs. In some cases, preferred provider agreements can help hold down health care costs. But PPOs are only effective in urbanized states where there is a large population concentration and an ability to shift a volume of patients.

In rural areas, PPOs could force small hospitals to close their doors. It's a lot different in Manhattan, Montana -- where a nearby hospital provides the only access to medical treatment -- than in Manhattan, New York where patients can choose from a wide variety of health care options.

In Montana's rural communities, a major insurer like Blue Cross/Blue Shield could pressure a community hospital to join its insurance plan -- and if they don't, the patient could be forced to go out of the community for hospital care.

A PPO network in a rural area could pit one community against another in a deadly competition. The loser in that kind of battle would be the community residents who lose access to nearby health care services.

SB 256 would protect hospitals from such unfair competition.

It would amend the Preferred Provider Act of 1987 to:

- Permit all providers who meet an insurer's "terms and conditions" to participate in the PPO arrangement;
 - Guarantee consumers' free choice of physicians and hospitals;
- and
- Prohibit exclusionary PPO arrangements.

MHA urges the committee to approve SB 256.

Thank you.

SAINT VINCENT HOSPITAL AND HEALTH CENTER
TESTIMONY IN FAVOR
OF THE
"WILLING PROVIDER ACT"

Saint Vincent Hospital and Health Center supports the "Willing Provider" Act, SB 256, and asks your concurrence. The bill received widespread support in the Montana Senate. For its third reading, the vote in favor of SB 256 was 38 - 12. It was supported by both Democrats and Republicans principally because it is "pro-consumer".

We want to emphasize that this legislation does not "outlaw" preferred provider arrangements or PPOs, but rather, insures that consumers, patients and businesses purchasing health care have access to hospitals, physicians, dentists, etc. who are willing to meet the terms and conditions set forth by either the purchaser or the insurance company representing the employer.

The main point I want to make here is that the issue of maintaining access between consumers and those willing and able to contract with them to provide service is maintained.

We would all agree that our objective is to keep health costs

down. However, there is nothing to insure that insurance companies are basing their contracting decisions on hospital or physician cost effectiveness or quality under the current situation. SB 256 will insure that.

SB 256 could actually improve current preferred provider arrangements inasmuch as it will insure that health care consumers and providers such as physicians and hospitals, have access to one another. A middleman such as Blue Cross cannot arbitrarily redirect business to the detriment of the consumer and/or employer. SB 256 will improve access for consumers and insure employers receive competitive rates.

The second point I want to make is that this type of law is necessary in a rural state such as Montana. Some may argue that this is only an issue in the communities where there are two hospitals. However, this issue affects all providers of health care, not just hospitals, but also physicians, dentists, chiropractors, optometrists, etc., and hence, is even more important to the smaller communities in the state. Wyoming passed "Willing Provider" legislation last year, principally

2
3-19-91
\$ 256

because of rural concerns, according to Senator Gary Yordy of Cheyenne, the bill's chief sponsor. Yordy told us that in his opinion PPO's were here to stay, so it is important for the legislators to focus on who they serve - and that is the consumer. By this legislation, we will insure that more Montanans may participate in preferred provider organizations. In Wyoming, this legislation was essentially unopposed except by Blue Cross/Blue Shield.

As you know, it is very often difficult to recruit health professionals such as physicians, optometrists, dentists, etc. to practice in rural communities. With the potential threat of exclusive physician agreements, that recruitment will become even more difficult. In both Wyoming and Montana, because of Blue Cross/Blue Shield's sheer size, it maintains the ability to carve out physicians. Those excluded, unfortunately, will be forced to abandon their practice in already under served rural areas.

Wyoming is not alone. Eleven (11) states have enacted "Willing Provider" legislation, seven of which are rural in nature:

Indiana
New Hampshire

Nebraska
North Dakota
New Mexico
Utah
Wyoming.

Why so many? In urban states or areas, there are many providers such as hospitals, physicians, dentists, etc., none of which dominate the market. The same is true of health insurance companies. In a state like Washington or Illinois, no insurance company dominates the market. Any provider can maintain exclusive agreements without threat to their continued existence. Unfortunately, as the State of Wyoming recognized, that is not the makeup of Montana. Here, Blue Cross/Blue Shield, in figures released by the State's Insurance Department for 1989, wrote commercial premiums totalling \$163 million out of \$333 million, or approximately 50%. The second largest company wrote only \$12 million. A handout is included in my testimony which illustrates this point.

The third issue is cost. Opponents have argued that this legislation will cause costs to increase. Blue Cross/Blue Shield and its allies maintain that this legislation will cause health care costs to rise. This simply has not occurred in rural states

with Willing Provider statutes. Four out of the five rural states with Willing Provider laws, rank 41st, 46th, 47th and 48th in terms of per capita health care costs, easily among the lowest in the country. Even Indiana, with some large metropolitan areas, ranked 32nd. The point is that these laws do not drive up health care costs. In fact, health care spending in these states is very low compared to the remainder of the United States:

	<u>RANK</u>	<u>1980</u>	<u>1990</u>
Indiana		32	32
New Hampshire		43	41
New Mexico		49	46
Utah		47	47
Wyoming		48	48

Another argument heard over the last several weeks is that if this legislation is enacted, physicians and hospitals would have little incentive to enter into preferred arrangements and give discounts because other providers will be able to meet these conditions. The point being made is, what incentive do hospitals have to control their costs? Currently there are only nine states in the country with health care costs on a per capita basis lower than the State of Montana. We would submit to you that, through safeguards such as voluntary rate review, health

care costs can be maintained. The issue of providers not willing to participate in contracting is simply not true. Yellowstone County has two very good examples of that. Both the Billings School District #2 and the Indian Health Services have been able to secure favorable rates from both Billings hospitals. These preferred provider arrangements have saved each of these organizations significant amounts on their health insurance costs. Both Indian Health Services and Billings School District #2 asked for and received discounted rates from both Billings hospitals. Neither were satisfied with just discounted rates; they wanted to preserve freedom of choice for their beneficiaries as well. That was a much more significant benefit: Savings coupled with choice. If approached on a reasonable basis, providers will willingly participate with employers to help them contain their health costs.

Montanan hospitals did not become the fifth lowest state in terms of costs per admission through exclusive PPO arrangements. They have been constantly endeavoring to lower the cost to patients and employers through such programs as:

- * Ask-A-Nurse - a free medical consultation service. There's no charge for this service and it prevents patients from making an unnecessary trip to the Emergency Room and/or physician's office. This saves companies like Blue Cross lots of money.
- * Prenatal care to expectant mothers and delivery care at whatever rate they can afford. That saves insurance companies and the State of Montana money.
- * Through the LifeCare program, many legislators themselves are cost effectively helped with wellness, minor emergency and/or occupational care. That saves Blue Cross money. LifeCare is keeping people healthy and "nipping problems in the bud".
- * Hospitals actually cooperate with insurance companies to review the accuracy of bills and control utilization. Hospitals do all the "leg work". This is saving insurance companies money.
- * In the personnel area, hospitals are relying more and more on volunteers because they cannot afford to hire someone; hospitals are consolidating positions to eliminate labor costs; 3 hospitals in Montana have received a Robert Wood Johnson grant to restructure patient care. Hospitals are restructuring personnel to reduce costs.
- * Hospitals are working with employers and insurance companies to shorten their stay in the hospital through same day admissions, same day surgery and/or utilization review.

This list could go on for some time. The point, however, is that hospitals are responding to helping employers and insurance companies control health care costs. No one forced hospitals to do this. They did it on their own volition. That's why Montana

is one of the very lowest health care cost states in the United States.

The fourth issue that needs to be addressed is choice. Health care is a very personal choice - one that should be agreed upon between the physician and patient. This can best be illustrated by each of us asking ourselves with whom or where would we trust the care of our parents, spouse, children, siblings, etc. When you are faced with critical decisions regarding their health, would you like an insurance company dictating which physician and/or hospital could care for those close to you? You would want care delivered by the physician and/or hospital that held your confidence and trust. Without SB 256, you could well lose that choice.

Finally, you may have received letters from insurance agents or companies in opposition to this legislation. I would ask two questions of each letter writer or witness: 1) Are you a Blue Cross agent or affiliated with Blue Cross? If the answer is yes, then their purpose of writing or testifying is obvious; if no, ask the second question. (2) How possibly can a company such as yours with less than 3 percent of the Montana health premium

market, be concerned about a Willing Provider statute? Most likely, policies written by other insurers in the State of Montana would not be exclusive, and therefore, the so called "Willing Provider" Act should be of little concern.

Once again, Saint Vincent Hospital recognizes the value of Preferred Provider Arrangements, but, also recognizes the destructive capability of exclusive arrangements in rural states, particularly when one health service corporation is so large and so dominant. Such ability to direct health care through a PPO can be destructive to hospitals, physicians, both urban and rural, unless other willing providers are allowed to meet the PPO's terms and conditions.

Please support the "Willing Provider" Act, SB 256. It will protect Montana citizens' ability to choose the provider with which they are most comfortable, the provider in which their confidence has been well placed in the past. This legislation focuses on the "little guy" - not the insurance company that is so dominant within Montana that it can effectively direct patient care - direction that should be coming from the patient and the

patient's physician. As a state, we need to recognize the wisdom in Wyoming's legislation which was designed to keep physicians in a rural state.

Thank you.

ACCIDENT AND HEALTH

EXHIBIT 2
DATE 3-19-91
\$B 256

INSURER

1989 DIRECT A & H
PREMIUMS WRITTEN IN MONTANA

BLUE CROSS/BLUE SHIELD OF MT.	\$162,957,526	48.94%
PRUDENTIAL INS. CO. OF AMERICA	\$12,481,653	3.75%
PRINCIPAL MUTUAL LIFE INS. CO	\$11,470,157	3.45%
CONTINENTAL ASSURANCE CO.	\$7,866,843	2.36%
BANKERS LIFE AND CASUALTY CO.	\$7,828,448	2.35%
MUTUAL OF OMAHA INS. CO.	\$5,675,593	1.70%
FEDERAL HOME LIFE INS. CO.	\$4,933,507	1.48%
STATE FARM MUTUAL AUTO INS. CO.	\$4,662,290	1.40%
JOHN ALDEN LIFE INS. CO.	\$4,600,358	1.38%
AETNA LIFE INS. CO.	\$4,429,966	1.33%
UNITED OF OMAHA LIFE INS. CO.	\$4,271,658	1.28%
TRAVELERS INS. CO.	\$3,349,172	1.01%
UNION BANKERS INS. CO.	\$3,324,206	1.00%
AETNA LIFE INSURANCE & ANNUITY CO.	\$3,312,481	0.99%
LIFE INVESTORS INS. CO. AMERICA	\$3,021,522	0.91%
COMBINED INSURANCE CO. OF AMERICA	\$2,793,424	0.84%
UNITED AMERICAN INS. CO.	\$2,758,867	0.83%
JOHN HANCOCK MUTUAL LIFE INS. CO.	\$2,612,540	0.78%
PROVIDENT LIFE & ACCIDENT INS. CO.	\$2,538,414	0.76%
LINCOLN NATIONAL LIFE INS. CO.	\$2,394,641	0.72%
CUNA MUTUAL INS. SOCIETY	\$2,624,780	0.79%
WASHINGTON NATIONAL INS. CO.	\$2,265,449	0.68%
PIONEER LIFE INS. CO. OF ILLINOIS	\$2,258,121	0.68%
NORTH CENTRAL LIFE INS. CO.	\$1,984,760	0.60%
NORTH AMERICAN LIFE AND CASUALTY	\$1,984,129	0.60%
UNIVERSE LIFE INS. CO.	\$1,963,762	0.59%
	-----	-----
TOTAL:	\$270,364,267	81.20%
TOTAL PREMIUMS PAID IN MT. IN 1989:	\$332,940,480	

SOURCE: MONTANA STATE AUDITOR'S OFFICE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

RATE

CONTROLS

/ SUPPLEMENT

an economic analysis service for healthcare management

EXHIBIT 2

PER CAPITA HEALTH SPENDING

\$B 256

VOLUME 14, NUMBER 12A

DECEMBER 15, 1990

Last month we discussed the report presented by two consumer groups, Families USA and Citizen Action. While the reports focused on a proposal for National Health Insurance, some of the supporting data was interesting and useful. Pages 5-7 are self-explanatory.

PER CAPITA HEALTH SPENDING

	1980 Amount	1980 Rank	1990 Amount	1990 Rank	2000 Amount
Massachusetts	1,284	1	3,031	1	6,890
California	1,186	4	2,894	2	6,584
New York	1,257	2	2,818	3	6,408
Nevada	1,109	8	2,757	4	6,272
Rhode Island	1,184	5	2,707	5	6,153
Connecticut	1,148	6	2,699	6	6,136
North Dakota	1,066	12	2,661	7	6,051
Illinois	1,093	11	2,619	8	5,953
D.C.	1,241	3	2,586	9	5,882
Michigan	1,097	10	2,569	10	5,840
Missouri	1,033	16	2,568	11	5,837
Kansas	1,057	13	2,548	12	5,792
Pennsylvania	1,021	17	2,536	13	5,763
Ohio	1,039	15	2,493	14	5,667
Minnesota	1,110	7	2,480	15	5,641
Hawaii	993	20	2,469	16	5,619
Nebraska	1,016	18	2,452	17	5,576
Wisconsin	1,097	9	2,449	18	5,567
Maryland	1,041	14	2,436	19	5,541
Florida	962	22	2,427	20	5,520
Colorado	996	19	2,415	21	5,495
Alaska	921	31	2,367	22	5,390
Iowa	993	21	2,351	23	5,343
South Dakota	952	24	2,322	23	5,278
Oregon	940	26	2,312	25	5,260
Washington	929	29	2,311	26	5,253
Alabama	924	30	2,286	27	5,201
Delaware	960	23	2,268	28	5,160
Tennessee	952	25	2,252	29	5,145
New Jersey	930	28	2,224	30	5,056
Arizona	848	39	2,211	31	5,031
* Indiana	919	32	2,201	32	5,004
Texas	915	33	2,192	33	4,987
Louisiana	940	27	2,185	34	4,972
Maine	870	36	2,175	35	4,945
Oklahoma	906	34	2,139	36	4,887
West Virginia	843	41	2,088	37	4,752
Virginia	863	37	2,076	38	4,724
Georgia	883	35	2,072	39	4,714
Montana	859	38	2,059	40	4,686
* New Hampshire	813	43	1,981	41	4,505
Vermont	815	42	1,956	42	4,443
Arkansas	844	40	1,944	43	4,423
Kentucky	806	44	1,875	44	4,266
North Carolina	773	45	1,833	45	4,170
* New Mexico	711	49	1,792	46	4,078
* Utah	741	47	1,784	47	4,052
* Wyoming	714	48	1,756	48	3,995
Mississippi	759	46	1,751	49	3,984
Idaho	708	50	1,726	50	3,928
TOTAL	\$1,016		\$2,425		\$5,515

* "WILLING PROVIDER" STATES

DATE 3-19-91

RANK	STATE	ADMISSIONS	DAYS	EXPENSES (THOUSANDS)	EXP/AD	EXP/AMT
1	MISSISSIPPI	391,312	2,407,494	1,424,376	\$590	\$3,640
2	SOUTH DAKOTA	94,480	581,713	410,881	\$710	\$4,350
3	KENTUCKY	531,588	3,299,417	2,324,127	\$700	\$4,370
4	ARKANSAS	335,459	2,194,816	1,472,091	\$670	\$4,390
5	MONTANA	102,883	550,423	473,364	\$860	\$4,600
6	WYOMING	50,984	240,650	236,914	\$980	\$4,650
7	ALABAMA	591,028	3,793,522	2,803,412	\$740	\$4,740
9	WISCONSIN	647,711	3,582,334	3,074,184	\$860	\$4,750
8	SOUTH CAROLIN	400,623	2,570,072	1,901,976	\$740	\$4,750
10	WEST VIRGINIA	278,728	1,720,173	1,346,226	\$780	\$4,830
11	IDAHO	91,951	489,749	445,041	\$910	\$4,840
12	KANSAS	302,255	2,054,174	1,480,873	\$720	\$4,900
13	OKLAHOMA	384,456	2,547,827	1,890,628	\$740	\$4,920
14	IOWA	379,091	2,600,697	1,915,548	\$740	\$5,050
15	TENNESSEE	792,544	5,093,533	4,010,435	\$790	\$5,060
17	NORTH DAKOTA	97,376	674,244	506,362	\$750	\$5,200
18	NORTH CAROLIN	775,971	5,392,792	4,036,155	\$750	\$5,200
16	VIRGINIA	703,114	4,549,550	3,653,328	\$800	\$5,200
19	NEW JERSEY	1,115,688	8,156,674	5,802,621	\$710	\$5,200
21	LOUISIANA	607,285	3,764,562	3,173,830	\$840	\$5,230
22	TEXAS	1,969,224	12,053,750	10,670,967	\$890	\$5,420
20	INDIANA	709,878	4,609,784	3,849,839	\$840	\$5,420
23	MARYLAND	554,781	3,723,347	3,007,115	\$810	\$5,420
24	VERMONT	57,625	384,443	315,360	\$820	\$5,470
25	NEBRASKA	182,738	1,250,925	1,010,808	\$810	\$5,530
26	NEW MEXICO	153,081	843,168	850,760	\$1,010	\$5,560
27	MAINE	145,846	1,032,196	830,075	\$800	\$5,690
28	OREGON	305,085	1,575,398	1,741,027	\$1,110	\$5,710
29	WASHINGTON	476,920	2,587,933	2,732,025	\$1,060	\$5,730
30	MINNESOTA	519,132	3,080,346	2,987,757	\$970	\$5,760
31	UTAH	171,154	909,426	989,382	\$1,090	\$5,780
32	ARIZONA	397,520	2,146,302	2,312,730	\$1,080	\$5,820
33	NEW HAMP	123,382	754,879	723,244	\$960	\$5,860
34	OHIO	1,525,619	10,140,342	9,037,414	\$890	\$5,920
	U.S.	30,968,558	207,277,919	183,241,828	\$880	\$5,920
35	MISSOURI	732,947	5,101,346	4,398,663	\$860	\$6,000
36	COLORADO	330,990	1,875,203	2,024,535	\$1,080	\$6,120
37	FLORIDA	1,609,436	11,033,533	9,935,655	\$900	\$6,170
38	PENNSYLVANIA	1,772,955	12,997,282	11,088,175	\$850	\$6,250
39	ILLINOIS	1,473,462	9,912,766	9,241,600	\$930	\$6,270
40	HAWAII	94,194	637,581	595,844	\$930	\$6,330
41	RHODE ISLAND	124,420	930,282	788,259	\$850	\$6,340
42	DELAWARE	81,301	557,485	517,870	\$930	\$6,370
43	NEVADA	112,892	675,894	729,014	\$1,080	\$6,460
44	MICHIGAN	1,096,168	7,528,197	7,565,891	\$1,000	\$6,900
45	CALIFORNIA	2,983,032	17,433,110	20,775,575	\$1,190	\$6,960
46	NEW YORK	2,329,965	21,434,640	17,155,260	\$800	\$7,360
47	CONNECTICUT	355,730	2,699,863	2,692,607	\$1,000	\$7,570
48	MASS.	800,369	6,107,894	6,159,899	\$1,010	\$7,700
49	ALASKA	38,483	187,799	302,294	\$1,610	\$7,810
50	D.C.	173,800	1,367,695	1,382,878	\$1,010	\$7,960
51	GEORGIA	554,781	3,723,347	4,466,734	\$1,200	\$8,050

Source: AHA 1989 Data Survey

Post-It™ brand fax transmittal memo 7671 [4 of pages]

To	Mark Euzenaki	From	Babolsen
Co.	Admin - St Vincent	Co.	MHA
Dept.	Adm - Files	Phone #	1-800-351-351
Fax #	1-571-71-73	Fax #	412-2544



**Questions and Answers on
SB 256 -- PPO Willing Provider Bill**

1. What is a PPO?

The Preferred Provider Organization statute was passed in 1987 and allows health care insurers such as Blue Cross/Blue Shield and AETNA to negotiate and contract with health care providers such as hospitals, doctors and treatment centers.

2. What does SB 256 do?

SB 256 allows a Willing Provider (hospital, doctor, mental health clinic, chemical dependency clinic, etc.) to meet the same terms and conditions established by the health care insurer and enables more consumers to participate.

Is there any precedent for this?

Yes, 11 states have Willing Provider statutes, seven of them are rural states like Wyoming.

3. Why is Willing Provider language needed?

Two specific reasons:

- 1) Montana is a rural state with struggling hospitals in non-urban areas. An arrangement to exclusively direct business away from one hospital to another or one doctor to another without allowing others to meet the same terms and conditions discriminates against both the patient and doctor or hospital.
- 2) Blue Cross/Blue Shield is the dominant health insurer in Montana (50% of accident and health policies in Montana) and a competing doctor or hospital could be financially crippled by being excluded.

4. Opponents say this bill will cause premiums to increase.

Blue Cross/Blue Shield uses this line everytime it opposes a bill. Information obtained to date indicates no problems with the Willing Provider statutes. Health care costs in Wyoming and Montana are among the lowest in the nation.

5. **Opponents say SB 256 would gut or eliminate PPOs, particularly for small groups?**

A Willing Provider bill will not in itself eliminate PPOs. PPOs are based on large volumes and volume shifts. The success of any PPO will depend on its cost competitiveness and the number of people who are enrolled.

6. **What about the State Plan?**

Montana state employees are covered by a self-insured fund. Blue Cross/Blue Shield administers the fund through a contract with the state. The state plan is not a PPO and Blue Cross/Blue Shield does not insure state employees.

7. **Has anyone been excluded yet?**

Yes. In the Billings market, one hospital has been excluded from participating in the PPO.

8. **Will PPO's affect rural hospital?**

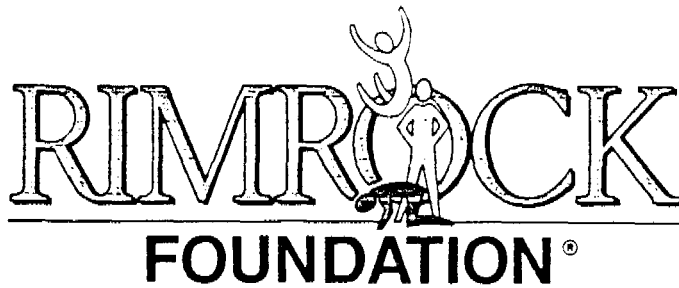
Although Blue Cross/Blue Shield has said that it isn't interested in trying PPO's in rural areas, the law allows them to do so. There is no patient volume to shift in rural areas.

Exclusive PPOs in urban areas may increase the referral of patients away from rural hospitals to urban hospitals. Rural hospitals cannot afford to lose local patients they now serve.

9. **Does this Bill have anything to do with limiting the cost of providers?**

Reducing insurance payments does not reduce the cost to provide health care services. Hospitals unable to reduce their costs will shift the payment burden to other payers.

In Montana, hospitals have little control over negotiations with a large insurance company like Blue Cross/Blue Shield.



Leading Quality Addiction Treatment in the Northern Rockies

EXHIBIT 3
DATE 3-19-91
HB 256

TESTIMONY IN SUPPORT OF SB 256
DAVID W. CUNNINGHAM, CEO

The bill before you today represents one of the most important pieces of legislation ever to confront small healthcare providers in Montana. It can virtually mean our continued existence or our demise.

Blue Cross in particular is expending large amounts of money and effort to convince you that exclusive arrangements, called Preferred Provider Agreements, are really in the best interests of low cost medical care and therefore you should not support this Willing Provider Bill.

Let me tell you what exclusivity may mean in the absence of this bill, over the long haul. Blue Cross has 44% of the market share in Montana and, in meetings with the Montana Chemical Dependency Programs this fall, indicated they only wanted three chemical dependency providers in their PPO. With a 44% market share, you don't have to be a rocket scientist to see the impact upon the rest of the providers, should Blue Cross choose only three state-wide.

The experience around our country from exclusivity has been monopoly...once a group with a large market share obtains exclusive agreements, they have a monopoly and become a destructive anti-competitive force. Under these conditions, initial price reductions designed to make them attractive, disappear and costs again increase.

We submit that an exclusive monopoly in a rural state like Montana with relatively few providers to begin with, has no merit. Small businesses in our state are needed and should be supported with this legislation, and not subjected to the threat of demise by one insurance company with a large market share and the "enticing promise" of short-term cost-savings.

Please level the playing field and pass SB 256!

EXHIBIT 4
DATE 3-19-91
SB 256

Wheatland Memorial Hospital
and Nursing Home

530 - 3rd Street N.W.
Box 287
Harlowton, Montana 59036
406-632-4351

WHEATLAND MEMORIAL HOSPITAL AND NURSING HOME

TESTIMONY IN FAVOR OF "SB 256"

MARCH 19, 1991

Wheatland Memorial Hospital and Nursing Home in Harlowton would like to support SB 256. The "Willing Provider Act" is crucial to viability and survival of rural hospitals in Montana.

Rural hospitals are at a critical crossroads. In a large, sparsely populated state like Montana, our outlying hospitals are crucial to the health needs and financial stability of our communities. The two biggest problems facing rural hospitals are money and physician availability. SB 256 helps us in both of these problems.

The bigger urban hospitals supply all Montanans with major medical services, but can't handle all the basic medical needs of Montana. When a major insurance company forms an exclusive PPO alliance with a bigger, urban hospital, it can direct patients from their own rural hospital to the urban facility.

In a small rural facility like Wheatland Memorial, doctor recruitment and retention is an ongoing problem. The potential consequences of a preferred provider agreement in a large, urban hospital would be to reduce the market share available to our local hospitals and physicians. If the people lose their right to decided where to get their basic health care, the small facilities will not survive.

In rural medical facilities especially, health care costs to the

Wheatland Mem. Hospital & Nursing Home

EXHIBIT 4
DATE 3-19-91
SB 256

patient are wide ranging and unique. A large percentage of rural hospitals are subsidized by County or Hospital District funds. The people living in these outlying areas already have a substantial investment in their local health care thru these subsidies. When a major insurance company steers patients to a "preferred provider" in an urban center, these people waste their investment in their local hospital. If this happens, is a PPO really saving the people of Montana money?

Another issue is the fact that the patient who needs to travel some distance to a "preferred provider" facility must take time off from work and pay travel costs. These expenses for basic health care can reduce the value of a PPO to the rural Montanan.

SB 256 would allow rural facilities to continue providing affordable, quality health care to their communities.

Thank you.

TESTIMONY OF CANDACE SELLERS, PRESIDENT
FAMILY HEALTH PLAN, INC.
IN FAVOR OF SB 256, THE "WILLING PROVIDER ACT"

EXHIBIT 5
DATE 3-19-91
SB 256

House Committee on Human Services and Aging
March 19, 1991

I am testifying on behalf of Family Health Plan, in favor of SB 256 "Willing Provider" Act because, from our perspective, managed care defined as solely provider discounts for steerage, is not a viable long term solution for minimizing health care costs. Furthermore, PPO's that are not evaluating the average costs per discharge for their contracted hospitals may, in fact, be providing financial incentives for plan participants to use a facility that is *more costly*, even with a discount, than a neighboring facility. For example, in 1988, Family Health Plan determined through claims analysis that costs at St. Vincent Hospital in Billings were on average 10% less than Billings Deaconess Medical Center for similar procedures. Therefore, had Deaconess elected to participate in Family Health Plan, their level of discount would have needed to be at least 10% better than St. Vincent's, to truly cause a cost benefit for employers participating in the Plan. With SB 256, both hospitals' rates would be available to an insurance company or employer; without SB 256 arbitrary decisions can be made.

Family Health Plan, Inc., is one of nine subsidiaries of Metrocare National, a Portland, Oregon, based health care holding company. As a corporate entity we have in excess of two million members participating in a variety of managed health care programs. We believe that managed care is essential to the continued viability of our current health care system, but certainly is not meant as a means to adversely affect the financial well being of a community's health care providers.

Effective managed care should be considered a partnership between payors, providers, and employers; all parties interested in the provision of quality health care services at a reasonable price. Payors and employers are looking for ways of minimizing their health care expenditures without compromising the level of service their members/employees receive. Exclusive PPO arrangements can decrease a member's benefits. In large metropolitan communities employers are prepared, and can afford to limit the number of providers available in a health plan without severely restricting choice. With the availability of hundreds of physicians and hospital beds, urban PPO's have had a positive impact on competition by directing volume to more efficient providers. This, *coupled with utilization management programs*, has brought documented savings to health insurance plans.

However, in a rural state like Montana, where the number of health care providers is already limited and one large insurance carrier has the financial clout to dictate terms, there is certainly a risk of eliminating competition which is bound to ultimately increase costs, decrease an employer's benefits, and potentially adversely affect quality.

PROPOSED AMENDMENTS TO SENATE BILL 256
Submitted by Blue Cross and Blue Shield of Montana

1. Page: 1
Line: 5
Following: "INSURERS TO"
Insert: "MAKE AVAILABLE THE OPPORTUNITY TO"
2. Page: 1
Line: 8
Following: "PROVIDER AGREEMENT,"
Insert: "TO REQUIRE PROVIDERS TO GIVE HEALTH CARE INSURERS AND SELF INSURERS AN OPPORTUNITY TO ENTER INTO PREFERRED PROVIDER AGREEMENTS;"
3. Page: 2
Line: 8
Following: "These terms and conditions may not"
Insert: "unfairly"
4. Page: 2
Line: 14
Following: "discrimination."
Strike: the remainder of line 14 through line 17
Insert: "(3) Before entering into an agreement with one or more providers under subsection (1), a health care insurer shall:
(a) Identify the geographic service area in which a proposed preferred provider agreement is to operate and the nature of the health care services to be provided; and
(b) Identify the providers of services for which a preferred provider agreement is contemplated within the geographic service area.
(4) In the event there is more than one provider identified by the health care insurer as a provider of services within the geographic service area, the health care insurer shall give all identified providers in the geographic service area an opportunity to submit a proposal for a preferred provider agreement.
(5) A preferred provider agreement for hospital services may not include as a part of its geographic service area a county in which there is only one hospital unless:

- (a) The hospital agrees to enter into a preferred provider agreement; or
- (b) The service covered by the agreement is not available at the hospital."

Renumber all subsequent subsections.

- 5. Page: 2
Following: Line 23
Insert: "(7) This part does not require that an insurer enter into agreements with any specific provider or class of providers.

"NEW SECTION. Section 2. Before entering into an agreement with one or more self-insured groups, a preferred provider shall give disability insurers and health service corporations operating within the proposed geographic service area an opportunity to submit a proposal for a preferred provider agreement."

Renumber all subsequent sections.

- 6. Page: 2
Line: 25
Following: "passage and approval"
Insert: "and applies to any preferred provider agreement entered into after the effective date of [this act]."



BUREAU OF COMPETITION

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

EXHIBIT 7
V89006 DATE 3-19-91

COMMISSION AUTHORIZED

Worby

May 30, 1989

The Honorable John C. Bartley
Massachusetts House of Representatives
State House
Boston, Massachusetts 02133

Dear Mr. Bartley:

The staff of the Bureau of Competition of the Federal Trade Commission is pleased to present its views on Massachusetts Senate Bill 526, entitled "An Act Providing For Accessibility To Pharmaceutical Services."¹ S. 526, if enacted, would require prepaid health benefits programs that include coverage of pharmaceutical services, and provide those services through contracts with pharmacies, either to allow all pharmacies to provide services to program subscribers on the same terms, or to offer subscribers the alternative of obtaining covered pharmaceutical services from any pharmacy they choose.

S. 526 appears intended to guarantee consumers greater freedom to choose where they will obtain covered pharmacy services. Thus, on quick inspection, it might be viewed as pro-competitive. For the reasons we discuss below, however, S. 526 actually may reduce competition in the markets for both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health benefits programs that they believe best meet their needs. The bill also appears to conflict with previously enacted statutes in Massachusetts that authorize the formation and operation of prepaid health care programs whose efficient operation is predicated on limiting the number of health care providers -- including providers of pharmaceutical services -- that may participate in such programs.

We believe that competition in the market for prepaid health care programs assures that subscribers to such programs will have access to a sufficient number of providers of pharmacy services. However, even if the legislature concludes that such access needs to be assured through regulation rather than market competition, there are means to achieve that aim that would be substantially less restrictive of competition and consumer choice than the provisions of S. 526. For these reasons, S. 526 appears likely to have as its primary effect the protection of some pharmacies from an aspect of marketplace competition, at the expense of consumers.

¹ These comments represent the views of the staff of the Bureau of Competition of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

I. Interest and Experience of the Federal Trade Commission ⁶⁸ 256

The Federal Trade Commission is empowered under 15 U.S.C. § 41 et seq., to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health professions, to the maximum extent compatible with other state and federal goals. For more than a decade, the Commission and its staff have investigated the competitive effects of restrictions on the business arrangements of hospitals and state-licensed health professionals.

The Commission has observed that competition among health care prepayment programs and among health care providers can enhance consumer choice and the availability of services, and lower the overall cost of health care. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.² As part of its efforts to foster the development of procompetitive health care programs, such as HMOs, which involve selective contracting with a limited panel of health care providers, the Commission has brought several law enforcement actions against anticompetitive efforts to prevent or eliminate such programs.³ The Commission also has supported federal "override" legislation that would have exempted PPOs from restrictive state laws and regulations that

² Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); Health Care Management Associates, 101 F.T.C. 1014, 1016 (1983) (advisory opinion); See also Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effect on Competition vi (1977).

³ See, e.g., American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (order modified 99 F.T.C. 440 (1982) and 100 F.T.C. 572 (1982)); Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order); Medical Staff of Doctors' Hospital of Prince George's County, No. C-3226 (FTC consent order issued Apr. 14, 1988; Eugene M. Addison, M.D., No. C-3243 (FTC consent order issued Nov. 15, 1988).

restrict or prevent the development of PPO programs, ^{HB such as 256} ~~"freedom of choice" or "any willing provider" provisions, which prevent PPOs from selectively contracting with a limited panel of providers.~~⁴ The Commission's staff, on request, also has submitted comments to federal and state government agencies explaining that various regulatory schemes would interfere unnecessarily with the operation of such procompetitive arrangements.⁵

II. The Proposed Legislation

S. 526 requires that "every carrier . . . providing or offering any group medical or other group health benefits contract or insurance which also provides or offers coverage for pharmaceutical services"⁶ must provide those pharmaceutical

⁴ See Statement of George W. Douglas, *supra* note 2; Letter from James C. Miller III, Chairman, Federal Trade Commission to Representative Ron Wyden (July 29, 1983) (commenting on H.R. 2956).

⁵ The Commission's staff has submitted comments with respect to a state prohibition of exclusive provider contracts between HMOs and physicians, noting that such a prohibition could be expected to hamper procompetitive activities of HMOs, and deny consumers the improved services that such competition would stimulate. Letter from Jeffrey I. Zuckerman, Director, Bureau of Competition, Federal Trade Commission, to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986). Similarly, the staff submitted comments to the Department of Health and Human Services suggesting that, in view of the procompetitive and cost-containment benefits of HMOs and PPOs, proposed Medicare and Medicaid anti-kickback regulations should not be written or interpreted so as to prohibit various common contractual relationships that HMOs and PPOs have with limited provider panels. Comments of the Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics Concerning the Development of Regulations Pursuant to the Medicare and Medicaid Anti-Kickback Statute at 6-13 (December 18, 1987).

⁶ There is some question as to the applicability of S. 526 to different types of third-party payors of health care benefits. For example, it is not entirely clear whether S. 526 would apply to programs offered by commercial insurance companies. On the one hand, the bill does not specify insurance companies in its enumeration of the types of firms that are included within the meaning of "carrier." On the other hand, the bill amends chapter 175 of the Massachusetts General Laws, which deals with accident and health insurance, and refers to "any group . . . health benefits contract or insurance which also provides or offers

DATE 3-19-91

BB 256

services through one or more of four types of arrangements specified in the bill: (1) direct provision of those services "in-house" by employees of the carrier; (2) contracts with groups of pharmacy services providers, with the proviso that "all eligible" providers be given an opportunity to participate on the same basis; (3) contracts with "select provider[s]," but with the requirement that the carrier also must offer subscribers an alternative whereby they may obtain pharmaceutical services from "a participating provider organization or group, which gives all tangible pharmacy providers⁷ an opportunity to participate"; and (4) use of an "affiliated non-profit clinic pharmacy."

Options (1) and (4) describe the ways that group or staff model HMOs -- which provide services to subscribers only at a few centralized locations -- typically operate. Thus, these types of HMO programs, which are in the minority in most states in both number of plans and number of subscribers, probably would be largely unaffected by S. 526.⁸ Most prepaid health care programs, however, do not provide covered services at only a few locations. Consequently, these programs would have to offer their covered pharmaceutical benefits through one of the other two options provided in S. 526. Because of this, S. 526, if enacted, may affect a large number of prepaid health care programs and their subscribers.

III. Analysis of S. 526

S. 526 may make it more difficult, or even impossible, for many third-party payors to offer, and consumers to select, programs including pharmaceutical coverage that have the cost savings and other advantages of prepaid health care programs that limit the number of providers that may participate in the

coverage for pharmaceutical services." (emphasis added). Similarly, although the bill states that covered "carriers" include health maintenance organizations, medical service corporations, and nonprofit hospital service corporations, the statutes that authorize and regulate these entities indicate that they are not subject to the state insurance laws, of which Chapter 175, which S. 526 amends, is a part. See Mass. Gen. Laws Ann. ch. 176G, § 2 (West 1987); ch. 176C, § 2 (West 1987); ch. 176A, § 1 (West 1987).

⁷ The term "tangible pharmacy provider" is not defined in the bill.

⁸ Some of these HMOs could be affected if, for example, they provide pharmaceutical services through an affiliated clinic pharmacy that is not non-profit.

program.⁹ To understand why S. 526 could have such adverse effects requires some explanation of how competition operates in the markets for health care services and prepaid health care programs, and the interrelationship of these markets.

A. The Market for Pharmaceutical Services
and the Prepaid Health Care Market

Providers of pharmacy services compete for the business of patients who need to have their prescriptions filled. Subscribers of prepaid health care programs that provide coverage for prescription drugs represent an increasingly important source of business for pharmacies.¹⁰ One way in which pharmacies compete for this segment of business is by seeking arrangements with payors that give them preferential, or even exclusive, access to a program's subscribers. Payors offer such preferential or exclusive arrangements to selected pharmacies (often pharmacy chains or networks of independent pharmacies) that offer the payor the lowest prices and best service. The payors include incentives in their subscriber contracts (e.g., lower deductibles and copayments) for subscribers to use the selected pharmacies or, in some cases, pay for services only if they are obtained at a contracting pharmacy. This assures the selected pharmacies of more business volume than if those subscribers spread their purchases among many providers.

This increased volume permits the pharmacies to take advantage of economies of scale, such as quantity discounts for large volume purchases, and to reduce their normal markup over cost for each prescription filled under the program. Third-party

⁹ Some payors may even cease offering coverage for prescription drugs at all, if the costs of complying with any of the options in S. 526 are too high for them to make such coverage available to subscribers at a competitive premium level.

¹⁰ In 1987, payments by private insurance for "drugs and medical sundries" were \$4.7 billion of the \$34.0 billion total spent for those items that year. S.W. Letsch, et al., "National Health Expenditures, 1987," 10 Health Care Financing Review 109, 115 (Winter 1988). Industry representatives estimate that, currently, about one-third of the \$23.6 billion consumers spend on prescription drugs are paid for by third-party programs. Statement of Boake A. Sells, Chairman and Chief Executive Officer, Revco Drug Stores, Inc., quoted in 11 Drug Store News 109 (May 1, 1989). Total expenditures for drugs and medical sundries are projected to increase to \$42.1 billion by 1990. Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, Department of Health and Human Services, "National Health Expenditures, 1986-2000," 8 Health Care Financing Review 1, 25 (Summer 1987).

DATE 3-19-91

payors find such arrangements attractive because pharmacies compete to offer lower prices and additional services. These benefits, in turn, help make the payor's programs more competitive in the prepaid health care market.¹¹ In addition, administrative costs to the payor may be less in this type of arrangement than where the payor must deal with all or most of the pharmacies doing business in a program's service area. Similarly, it may be easier for a payor to implement cost-control programs, such as claims audits and utilization review, where it has a limited number of pharmacies whose records must be reviewed.

Subscribers who choose these programs benefit to the extent that the lower pharmaceutical costs offered by the contracting pharmacies are reflected in lower premium costs. Subscribers selecting such programs make a conscious choice that, for them, the benefits of lower premiums, lower deductibles and copayments, and perhaps broader coverage, outweigh whatever minor inconvenience they may encounter from having a more limited choice of pharmacies. Nor are subscribers likely to face inadequate access to providers, including pharmacies, despite a program's use of a limited provider panel. Subscribers can change payors or programs, and obtain their health care coverage from another source that offers a better alternative, if the service availability in a particular program is insufficient or inconvenient. Subscribers' ability to "vote with their feet" if they are dissatisfied provides the necessary incentive for payors to assure that subscribers are satisfied with their access to covered health care services.

B. Effects of S. 526 on the Market for Pharmaceutical Services and on the Prepaid Health Care Market

S. 526, if enacted, may make it difficult or impossible for many payors to offer subscribers prepaid health care programs that have the cost and coverage advantages described above. As mentioned previously, the in-house and affiliated clinic pharmacy approaches are feasible only for a few types of programs. One of S. 526's remaining options is to open the program to all pharmacy firms or groups willing to contract on the same terms. Without the expectation of obtaining a substantial portion of subscribers' business, however, contracting pharmacies may be unable to achieve the scale economies that permit them to offer lower price terms or

¹¹ In the event that competition among prepaid health care programs or among providers of pharmaceutical services is reduced, for example by regulatory constraints, the benefits associated with permitting prepaid health care programs to enter into arrangements with a limited number of health care providers may be diminished.

additional services to payors. Moreover, since any pharmacy would be entitled to contract with a payor on the same terms as other contracting pharmacies, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals. Since all other pharmacies could "free ride" on the first pharmacy's proposal, innovative providers of pharmacy services probably would be unwilling to bear the costs of developing a proposal. This provision of S. 526 therefore may substantially reduce competition among pharmacies for this segment of their business.

The higher prices that some programs would have to pay for pharmacy services, as well as the increased administrative costs, would be expected to raise the premiums that those payors must charge for programs that include pharmacy benefits, or might force them to reduce their benefits in order to avoid raising premiums. Either of these effects could reduce some payors' ability to compete, since their programs would be less attractive than before relative to other programs whose operations, and costs, would remain unaffected by S. 526.

The disadvantages to subscribers of requiring payors to open their programs to all pharmacies may include higher premium costs or the loss of broader coverage provisions, including lower deductibles and copayments for pharmacy services, that programs otherwise could provide due to the cost savings obtained through limiting provider participation.¹² Thus, requiring payors to allow all pharmacies to participate in their programs may either raise prices to consumers or eliminate the choice they otherwise would have to select a program that gives them certain coverage and payment benefits in exchange for agreeing to limit their choice of pharmacies. Subscribers already may select other types of prepayment programs, such as indemnity insurance, that do not limit the pharmacies from which they may obtain covered services. Thus, requiring open pharmacy participation may reduce the number and variety of prepayment programs available to consumers without providing any additional consumer benefit.

The final option for payors under S. 526 is to offer subscribers, in addition to any program that limits pharmacy participation, an alternative under which subscribers essentially would be entitled to use any pharmacy. This option also gives subscribers little additional choice, since they already may choose a program that does not limit where they may obtain covered pharmaceutical (and other) services when they select a prepaid health care program. Moreover, complying with this

¹² Even if an employer pays the entire premium cost of its employees' coverage, higher premiums could represent a loss to consumers since those monies could be used to pay for additional coverage or other employee benefits.

option of S. 526 may entail substantial administrative burdens and expenses for payors. As discussed previously, the pharmacy costs and administrative expenses of an "open-panel"¹³ program are likely to be higher than those where the provider panel is limited. Consequently, either the premiums for the payor's open-panel alternative would need to be higher, or the benefits reduced. Since subscribers who enroll in prepaid health care programs that limit provider participation do so in order to obtain the cost and coverage advantages that such programs provide, it is questionable whether many of those subscribers would opt for an alternative that eliminated those advantages with regard to pharmacy benefits.

Massachusetts already has recognized the benefits of programs that limit participation by providers, including pharmacies, by enacting various statutes that authorize the formation and operation of such programs. Just last year, Massachusetts adopted legislation authorizing "preferred provider arrangements,"¹⁴ which permits payors offering such programs to contract selectively with health care providers, including providers of pharmaceutical services,¹⁵ so long as selection of those providers is based "primarily on cost, availability and quality of covered services."¹⁶ In addition, the legislature adopted statutory provisions authorizing nonprofit hospital corporations, medical service corporations, HMOs, and commercial insurance companies to "establish, maintain, operate, own, or offer" preferred provider arrangements approved by the Insurance Commissioner. Similarly, for more than a decade, Massachusetts has, by statute, authorized the formation and operation of HMOs, which provide services to subscribers through selected health care providers with whom the HMO generally has a contractual agreement. Adoption of S. 526 would appear to be anomalous in

¹³ An "open-panel" program does not restrict the number of providers that may participate in it, although all participating providers must agree to the program's payment terms and other requirements of participation. Other programs, such as indemnity insurance, do not even have participation agreements with providers, so that subscribers may obtain covered services from essentially any licensed provider of those services.

¹⁴ Mass. Gen. Laws Ann. ch. 176I (West 1989 Supp.)

¹⁵ The statute defines "health care providers" as including, among others, registered pharmacists, persons licensed to engage in the sale, distribution, or delivery, at wholesale, of drugs or medicines, and stores registered and licensed for transacting retail drug business. Ch. 176I, § 1, referencing Mass. Gen Laws Ann. ch. 112 (West 1983 and 1989 Supp.).

¹⁶ Ch. 176I, § 4.

light of these statutes, since it might prevent many such programs from operating, at least with regard to covered pharmacy services, in the ways envisioned and authorized by existing statutes.

Finally, if the legislature concludes that subscribers who voluntarily select health care prepayment programs that limit their choice of pharmacies nevertheless require additional regulatory protection to assure that they have adequate sources for pharmacy services, alternatives exist that are less restrictive of competition and less harmful to consumers than S. 526's approach. For example, the state could require payors to demonstrate, as part of their current regulation under the insurance laws, that their programs provide adequate access to services for their subscribers, leaving the payors free to decide precisely how to meet the requirement. This approach would meet the concern that subscribers have adequate access to services, while leaving the payors free to compete for subscribers on the basis of how successfully they please subscribers in providing such access. In fact, this type of approach is similar to what Massachusetts appears to have adopted in authorizing the establishment and operation of preferred provider arrangements and HMOs.¹⁷

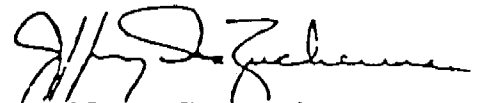
In summary, we believe that S. 526 may reduce competition in the markets for both prepaid health care programs and pharmaceutical services provided to such programs. As a consequence, it may raise prices to consumers and unnecessarily restrict their freedom to choose health benefits programs that they believe best meet their needs.

¹⁷ Mass. Gen. Laws Ann. ch. 176I, § 2(c) (West 1989 Supp.) provides that preferred provider arrangements must meet "standards [apparently to be promulgated by the Commissioner of Insurance] for assuring reasonable levels of access of [sic] health care services and geographical distribution of preferred providers to render those services." Massachusetts law requires HMOs to include in their subscriber contracts information on "the locations where, and the manner in which health services and any other benefits may be obtained." Mass. Gen. Laws Ann. ch. 176G, § 7(4) (West 1987). These HMO subscriber contracts are subject to disapproval by the Insurance Commissioner if "the benefits provided therein are unreasonable in relation to the rate charged," (Ch. 176G, § 16) and the Commissioner is authorized to promulgate rules and regulations as necessary to carry out the provisions of the act. (Ch. 176G, § 17).

We hope these comments are of assistance.

EXHIBIT 7
DATE 3-19-91
SB 256

Sincerely yours,


Jeffrey I. Zuckerman
Director

Spencer's research reports

on employee benefits

January 19, 1990

DOL Publishes Book On Private Pension System

Assets of the private pension system grew six times faster than the whole U.S. economy between 1950 and 1987, according to a book published by the Department of Labor's Pension and Welfare Benefits Administration (PWBA).

The book, entitled *Trends in Pensions*, includes discussion of pension coverage, asset reversion, pensions and mergers, investment performance, retiree benefits, the funding status of private pension plans, and statistical comparability of eight international pension systems. In addition, the book provides statistical data on Social Security, governmental retirement programs, individual retirement accounts, and privately purchased annuities.

The book's analyses of major trends and current policy issues found the following:

- private pension assets grew at a rate almost six times faster than the total financial assets of the whole economy, increasing from \$17 billion in 1950 to nearly \$2 trillion in 1987;
- private pension coverage remained relatively stable for 15 years at 53% of full-time workers, but more workers enjoyed dual coverage from a supplemental defined contribution plan;
- plans and participants in supplemental defined contribution plans rose dramatically from 1975 to 1985, with supplemental coverage increasing from 21% to 40% of all plan participants;
- four-fifths of all plans had sufficient assets to pay accrued benefits upon termination in 1985, compared to less than 35% of plans in 1974;
- the association between pension terminations and corporate takeovers stems more from a trend toward efficient corporate restructuring than accessing pension assets; and
- vesting increased from 48% of primary plan participants in 1977 to 56% in 1985.

The book also contains 200 statistical tables on a broad range of plan financial characteristics.

The 500-page book was developed by the PWBA's Office of Research and Economic Analysis. Articles and data were contributed by research analysts from other government agencies and the private sector.

Copies of the book may be purchased for \$14 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. The stock number is 029-000-00427-7.□

Survey Indicates Employers, Employees Are Satisfied With Preferred Provider Organizations

The American Association of Preferred Provider Organizations (AAPPO) has announced the findings of its recent survey of employee health care benefits. According to AAPPO chairman Jim Kent, the results of the survey confirm the association's premise that there is high employer and employee satisfaction with the PPO concept.

Approximately 24% of the 638 companies involved in the survey offered a PPO to their employees. Of that number, 77% said they were either very or somewhat satisfied with their health care provider.

The primary reason given for employer satisfaction was the PPO's ability to control benefits costs for their firms. Deductibles and copayments were named by 87% of the respondents as the methods the companies themselves used to control costs.

The survey was conducted in the country's 49 largest metropolitan areas. The responding companies were equally divided between service and manufacturing, with employee populations ranging from 50 employees to 10,000 employees.

"The satisfaction of their employees was cited as the second most important reason for the purchasers' satisfaction with their PPO," Mr. Kent noted. "In fact, when choosing a health care plan, 62% of the respondents rated employee satisfaction as very important to the decision process, and another 25% said employee satisfaction was at least somewhat important," he said.

"Of the respondents not offering a PPO, 19% had tried but rejected a PPO within the last two years. One of the reasons offered was that they sensed the costs were too high, a surprising response in light of the reasons given by PPO users for their high degree of satisfaction," Mr. Kent stated.

For more information, call the AAPPO at (312) 644-6610, extension 3270.□

EXHIBIT 9
DATE 3-19-91
SB 256

March 19, 1991

SENATE BILL 256
BEFORE HOUSE HUMAN SERVICES & AGING COMMITTEE

Testimony of David Hartman
Montana Education Association

IN OPPOSITION TO SB 256

Senate Bill 256 will effectively eliminate preferred provider agreements in Montana between employee groups, their employers and health care providers. It does so by requiring that the terms of preferred provider agreements must be opened up to all health care providers who are willing to meet the terms of the agreement as to charges for services.

Preferred provider agreements are possible only because health care providers are willing to discount the cost of their services in return for being guaranteed a block of business from an identified group of employees or other consumers in return for the discounted price.

Preferred provider agreements have become increasingly popular nationwide because they help to control the escalating cost of health care services.

By giving other health care providers equal access to this block of business, the incentive for discounted rates is destroyed, thus no more such arrangements because the block of business is no longer guaranteed to any health care provider.

SB 256 will see the end of preferred provider agreements in Montana and will add to the inflationary spiral in health care costs. This bill unfairly restrains consumers, employees and employers as they struggle to control the cost of health care services.

Proponents of this bill in the Senate included a spokesperson for Montana's rural hospitals who expressed concern about the future of these small institutions. While our rural hospitals may be in trouble financially, their troubles are not the result of preferred provider agreements, which focus upon urban areas where there is competition in the health care industry, whether the competition is between physician clinics or hospitals. To be both effective and possible, preferred provider agreements exist where there is competition between providers for customers. This isn't the case in our smaller communities which have only one hospital and usually only one physician clinic.

-OVER-

The fact of the matter is, the most vocal proponents of SB 256 are representatives of health care providers in our major urban areas who lost out to the competition in a preferred provider arrangement. The next time around, these providers can sharpen their pencils in negotiations on preferred provider agreements and hope to secure the block of consumer business which now goes to a competing provider, whether that provider is an urban clinic, an urban hospital, or an urban chemical dependency treatment center.

The cost of health care and insurance for health care is the result of three forces: Cost of services x quantity of service x type of service. Preferred provider agreements give consumers, employees and employers the opportunity to address the first force: Cost of service.

Hundreds of preferred provider agreements exist nationwide, including several in Montana. I urge the Committee to continue permitting consumers ways to explore means by which they can control health care costs and the costs of health insurance premiums and contributions. I urge your "Do Not Pass" action on SB 256.

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

10
DATE 3-19-91
SB 256



STAN STEPHENS, GOVERNOR

ROOM 130, MITCHELL BUILDING

STATE OF MONTANA

(406) 444-3871

HELENA, MONTANA 59620

Testimony in opposition to SB256.
before the House Human Services Committee

Madam Chairman, members of the Committee, I am Joyce Brown, Chief of the Employee Benefits Bureau, Department of Administration, which administers the State employee health plan. Following is an outline of my testimony.

The State Health Plan, which is a self-insured plan, does not currently participate in any Preferred Provider Organizations (PPOs). We oppose this bill because we want to preserve the option to do so in the future.

SB256 would effectively gut statutes providing for PPOs before they have a chance to form, and PPOs are regarded by many health plan administrators as the most effective health care cost control mechanism available.

HOW DOES SB256 GUT PPO LEGISLATION? It requires a health insurer to extend PPO agreement terms and conditions to any health care provider willing to accept them. ISN'T THIS ONLY FAIR? No, a PPO is an agreement in which an insurer offers a larger share of the health market in exchange for reasonable prices. If the insurer must offer the same terms and conditions to all health care providers the insurer can't promise a larger share of the health care market -- the carrot and any incentive to enter a PPO agreement is lost.

Imagine what kind of bids for services the State would receive if those bidding on state services knew that they could be included in any contract with the successful bidder?

If you agree with the following premises, I think you will agree that SB256 is, bad public policy:

1. Health care costs cannot continue to rise at current rates.

Increases are fueling a destructive spiral: individuals and employers are being priced out of the health care market which results in cost shifting to the remaining insureds which forces still more into the ranks of the uninsured or underinsured.

The State health plan is similar to other employer plans in that funding has not kept pace with cost increases forcing benefit cuts and cost shifting to plan members.

3-19-91

S. 256

2. Since neither federal or state government show signs of controlling costs, the task is left to consumers in cooperation with their third party payer (their insurance company or claims processor for self-insured groups).

3. Market forces -- the ability and willingness of consumers to pay as a control on costs is already tenuous when it comes to the health care industry.

Health care providers determine what medical services are needed and what the costs will be. Consumers generally do not have the expertise to refuse unnecessary services, nor do they have any power to negotiate reasonable rates except through their insurer.

4. The last thing that is needed is a bill that further restricts the ability of health insurers to control runaway costs.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

1 of 2

Human Services & Aging

COMMITTEE

BILL NO. SB 256

DATE 3-19-91

SPONSOR(S) Sen. Gage

PLEASE PRINT

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GARY RICHARDS, Bgs	SELF		X
TERRY Mammenga	Tractor & Equipment CO T & E		X
Joseph HANSEN	Self	X	
David Cunningham	Rumracks Fdn	X	
DICK FELLOWS	FIRST Interstate Banks		X
Leni Caputo	SAINT VINCENT HOSPITAL	X	
Bob Jones	Wheatland Mem Hosp.	X	
Doug LaFull	Community Medial Center ^{M.S.H.}	X	
Candace Sellers	Family Health Plan	X	
Mark A. Burzynski BGS, MT	Trinity Hospital Wolf Port	X	
David Engert	SELF	X	
Dave Barnhill	Yellowstone County Insurance dept.		X
Dore Barnhill	Insurance dept.	X	
E. J. Mayalsky Edrine Mammenga	Self	X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

2 of 2

Human Services

COMMITTEE

BILL NO. SB 256

DATE 3-19-91 SPONSOR(S) Sen Gage

PLEASE PRINT

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Vicky Locke	self	X	
DAVID HARTMAN	MEH		X
Pat Melby	Rimrock Foundation	✓	
Steve Brown	Blue Cross - Blue Shield		X
Mike Ruppert	CDPM	X	
Cal Woods	Dexcross Medical Center		X
Mary McCue	Mt Mental Health Council Assn	X	
Rose Hughes	Mt. Optometric	X	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS		X
Joyce Brown	Dept. of Administration		X
James Tutwiler	UT CHAMBER COM		✓
John DeLano	Mont Med Assn	X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging

COMMITTEE

BILL NO.

SB

256

DATE 3/19/91

SPONSOR(S)

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Mora Jamison	RMTc	✓	
Joel Lankford	Columbus Hospital	✓	
Jess Hogan	Saint Vincent Hospital	✓	
David Barnhill	Deputy Insurance Commissioner	✓	
Joe Ebrey	St Vincent Hosp	✓	
Tom Hopgood	Health Fns Assoc. America		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

the amendment, that situation would not change.

REP. S. RICE stated that the original bill stated that you must add people to get the various groups represented. Under the amendment, you have the choice of already having the consumers on the board or adding people to make sure that the consumers are put on the board. If the board doesn't have the consumers, they will just have to add them to the board.

REP. TUNBY stated that he speaks against the amendment. He thinks the board should have a chance to replace these members as they came up.

REP. WHALEN stated that if you have already have three people on the board that need this criteria, they are going to have greater voting power then if they are added onto the board.

REP. KASTEN stated that the amendment isn't structured exactly as we would like it to be, it is very much on track as far as Eastern Montana is concerned. The 17 members represent 17 counties.

Vote: Motion carried 17-3 with REPS. HANSEN, MESSMORE and STRIZICH voting no.

Motion/Vote: REP. MESSMORE MOVED SB 326 BE CONCURRED IN AS AMENDED. Motion carried 19-1 with REP. CROMLEY voting no.

EXECUTIVE ACTION ON SB 256

Motion: REP. WHALEN MOVED SB 256 BE CONCURRED IN.

Discussion:

REP. WHALEN stated that it is his understanding that whether this informs the National Association of Insurance Commissioners (NAIC) on preferred provider agreements, or not, this is a good piece of legislation. At the NAIC conventions, you basically have five insurance groups for every single regulator and anything that they adopt tends to be very much watered down. The Insurance Commissioners Office supports this bill without amendments.

REP. DOWELL stated that we have a situation where there is a business that has basically 50% of a market share. They are cutting a particular deal with an individual business in the city. When these type of practices occur, they would be called monopolistic.

REP. JOHNSON stated that there is one basic difference between what a claims management services do and what health insured does. The health insured actually pays for claims, the claims management services is nothing more than the people who do the bookkeeping for that services.

Vote: Motion carried. EXHIBIT 4

EXECUTIVE ACTION ON SB 366

Motion: REP. STICKNEY MOVED SB 366 BE CONCURRED IN.

Motion/Vote: REP. STICKNEY moved to amend SB 366. EXHIBIT 5.
Motion carried. EXHIBIT 6

Motion/Vote: REP. MESSMORE MOVED SB 366 BE CONCURRED IN AS
AMENDED. Motion carried 17-3 with REPS. BOHARSKI, KASTEN and LEE
voting no.

EXECUTIVE ACTION ON SB 393

Motion: REP. MESSMORE MOVED SB 393 BE CONCURRED IN.

Motion/Vote: REP. CROMLEY moved to amend SB 393. EXHIBIT 7.
Motion carried unanimously.

Motion/Vote: REP. MESSMORE MOVED SB 393 BE CONCURRED IN AS
AMENDED. Motion carried unanimously.

EXECUTIVE ACTION ON HB 93

Motion: REP. S. RICE MOVED HB 93 DO PASS.

Discussion:

REP. S. RICE submitted testimony on amendments. EXHIBIT 8

Motion/Vote: REP. S. RICE moved to amend HB 93. EXHIBIT 9.
Motion carried unanimously.

Motion: REP. S. RICE moved to amend HB 93. EXHIBIT 10

Discussion:

REP. TUNBY asked the Department of Social and Rehabilitation Services (SRS) if they agree with the amendments. Julia Robinson, Director, SRS, stated that these amendments are above the Governor's budget, however they are funded without pitting the General Fund. We have not taken a position on whether the Governor would report them. REP. S. RICE stated that there is no General Fund impact on the Health Care Association's amendment.

REP. KASTEN asked which bill are we adding these amendments to, the original bill or the gray bill. REP. S. RICE stated that these would be added to the gray bill.

Vote: Motion carried 19-1 with REP. MESSMORE voting no.

HEARING ON SB 172

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL

DATE 3-22-91

NAME	PRESENT	ABSENT	EXCUSED
REP. ANGELA RUSSELL, CHAIR	✓		
REP. TIM WHALEN, VICE-CHAIR	✓		
REP. ARLENE BECKER	✓		
REP. WILLIAM BOHARSKI	✓		
REP. JAN BROWN	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. PATRICK GALVIN			✓
REP. STELLA JEAN HANSEN	✓		
REP. ROYAL JOHNSON	✓		
REP. BETTY LOU KASTEN	✓		
REP. THOMAS LEE	✓		
REP. CHARLOTTE MESSMORE	✓		
REP. JIM RICE	✓		
REP. SHEILA RICE	✓		
REP. WILBUR SPRING	✓		
REP. CAROLYN SQUIRES	✓		
REP. JESSICA STICKNEY	✓		
REP. BILL STRIZICH	✓		
REP. ROLPH TUNBY	✓		

EXHIBIT T
DATE 3-22-91
SB 256

HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE

ROLL CALL VOTE

DATE 3-22-91 BILL NO. SB 256 NUMBER 1

MOTION: Rep Whalen's SB 256 Be Concurred In.

NAME	AYE	NO
REP. TIM WHALEN, VICE-CHAIRMAN	✓	
REP. ARLENE BECKER	✓	
REP. WILLIAM BOHARSKI		✓
REP. JAN BROWN		✓
REP. BRENT CROMLEY	✓	
REP. TIM DOWELL	✓	
REP. PATRICK GALVIN	✓	
REP. STELLA JEAN HANSEN	✓	
REP. ROYAL JOHNSON	✓	
REP. BETTY LOU KASTEN		✓
REP. THOMAS LEE	✓	
REP. CHARLOTTE MESSMORE	✓	
REP. JIM RICE		✓
REP. SHEILA RICE	✓	
REP. WILBUR SPRING	✓	
REP. CAROLYN SQUIRES	✓	
REP. JESSICA STICKNEY	✓	
REP. BILL STRIZICH	✓	
REP. ROLPH TUNBY	✓	
REP. ANGELA RUSSELL, CHAIR	✓	
TOTAL	16	4

10:55
3-27-9
JDR

HOUSE STANDING COMMITTEE REPORT

March 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that Senate Bill 256 (third reading copy -- blue) be
concurrent in .

Signed: _____
Angela Russell, Chairman

Carried by: Rep. R. Johnson

SENATE BILL NO. 256

INTRODUCED BY GAGE, LYNCH

A BILL FOR AN ACT ENTITLED: "AN ACT AMENDING THE PREFERRED PROVIDER AGREEMENTS ACT TO REQUIRE HEALTH CARE INSURERS TO ENTER INTO PREFERRED PROVIDER AGREEMENTS WITH ALL HEALTH CARE PROVIDERS WILLING TO PROVIDE HEALTH CARE SERVICES UNDER A PREFERRED PROVIDER AGREEMENT; AMENDING SECTION 33-22-1704, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-1704, MCA, is amended to read:

"33-22-1704. Preferred provider agreements authorized.

(1) Notwithstanding any other provision of law to the contrary, a health care insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:

(i) the amounts an insured may be charged for services rendered; and

(ii) the amount and manner of payment to the provider; and

(b) issue or administer policies or subscriber

contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).

(2) A health care insurer shall establish terms and conditions to be met by providers wishing to enter into an agreement with the health care insurer under subsection (1)(a). These terms and conditions may not discriminate against or among providers. For the purposes of this subsection, price differences among hospitals or other institutional providers produced by a process of individual negotiation or by price differences among different geographical areas or different specialties do not constitute discrimination. A health care insurer may not deny a provider the right to enter into an agreement under subsection (1)(a) if the provider is willing to meet the terms and conditions established in that agreement.

~~(2)(3)~~ A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.

~~(3)--This--part--does--not--require--that--an--insurer negotiate--or--enter--into--agreements--with--any--specific provider--or--class--of--providers--"~~

NEW SECTION. **Section 2.** Effective date. [This act] is effective on passage and approval.

-End-

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GOVERNOR'S AMENDMENTS
TO HOUSE BILL 256
(REFERENCE COPY, AS AMENDED)
MARCH 19, 1991

1. Page 2, line 22
Strike: "1.9%"
Insert: "1.85%"

GOVERNOR'S AMENDMENTS TO
SENATE BILL 256
(REFERENCE COPY, AS AMENDED)
April 17, 1991

1. Page 2, following line 25
Insert: "NEW SECTION. SECTION 3. Termination. [This Act]
terminates July 1, 1993."

Gov. Amend.
SB 256

SENATE BILL NO. 256

INTRODUCED BY GAGE, LYNCH

A BILL FOR AN ACT ENTITLED: "AN ACT AMENDING THE PREFERRED PROVIDER AGREEMENTS ACT TO REQUIRE HEALTH CARE INSURERS TO ENTER INTO PREFERRED PROVIDER AGREEMENTS WITH ALL HEALTH CARE PROVIDERS WILLING TO PROVIDE HEALTH CARE SERVICES UNDER A PREFERRED PROVIDER AGREEMENT; AMENDING SECTION 33-22-1704, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A TERMINATION DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-1704, MCA, is amended to read:

"33-22-1704. Preferred provider agreements authorized.

(1) Notwithstanding any other provision of law to the contrary, a health care insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:

(i) the amounts an insured may be charged for services rendered; and

(ii) the amount and manner of payment to the provider; and

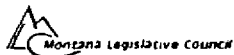
(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).

(2) A health care insurer shall establish terms and conditions to be met by providers wishing to enter into an agreement with the health care insurer under subsection (1)(a). These terms and conditions may not discriminate against or among providers. For the purposes of this subsection, price differences among hospitals or other institutional providers produced by a process of individual negotiation or by price differences among different geographical areas or different specialties do not constitute discrimination. A health care insurer may not deny a provider the right to enter into an agreement under subsection (1)(a) if the provider is willing to meet the terms and conditions established in that agreement.

~~{2}{3}~~ A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.

~~{3}--This---part---does---not---require---that---an---insurer negotiate--or--enter--into--agreements--with--any---specific provider-or-class-of-providers--"~~

NEW SECTION. **Section 2.** Effective date. [This act] is



SB 0256/03

1 effective on passage and approval.

2 NEW SECTION. **Section 3. Termination.** [This act]

3 terminates July 1, 1993.

-End-